Detailed File Report

5756812 - Nelson Marlborough District Health Board - Assessment

File Details

File Title: 5756812 - Nelson Marlborough District Health Board - Assessment

Trigger: WEPR

CRM: No

CRP: No

Rationale: Request for review of PIN by NMDHB

Date Initiated: 26/07/2019

Nearest Town/City: Nelson

Assigned To: Sue Cunningham

Industry: Hospitals (except Psychiatric Hospitals)

Focus Area: Other Priority Area

Request Type: Review of PIN

What was assessed: Other

File Status

Status: Open

Parties

Client ID	Name	Roles/Duties	Contact Name	Primary Party	Victim
18875494	9(2)(a)	Worker		False	
3067604	Nelson Marlborough District Health Board	PCBU	9(2)(a)	True	

Assessments

Status: Closed

End Date: 21/08/2019

TLM Assessments

None

Outline of Intended Process: Review PIN (Refer to PIN Review policy)

Meet with HSR and NZNO organisor to discuss PIN and gain understanding of background/underlying causes

Meet with NMDHB representative to PIN and gain understanding of background/underlying causes

Establish whether PIN valid/upheld and WEPR processes are effective/compliant with HSWA

Use EDM to arrive at any enforcement decision

Advise all parties of outcome

Type	Location	Details	H&S Rep/Worker Interaction	H&S Rep/Worker Name	Date
Workplace Assessment Visit	NMDHB Waimea Road, Nelson	Meeting with NMDHB as part of PIN review and assessment of worker engagement process.	Yes	9(2)(a)	12/08/2019
Assisting Workplace Assessment Visit	NMDHB, Waimea Road, Nelson	Assisting with meeting with NMDHB re background for PIN review and assess WEPR processes.	No		21/08/2019
Worker Engagement, Participation and Representation	Nelson	Meet with HSR 9(2) 9(2)(a) and NZNO Organiser 9(2)(a) to discuss PIN,	No		30/07/2019

WEPR processes and background to issues.

Worker Participation System

Did you speak to an H & S Rep: No

Reason for not speaking to an H & S Rep?: Other

Other reason: Already meet with HSR; this meeting to hear NMDHB

Did you speak to a Worker: Yes - add Rep. details

Type: Worker

Name: 9(2)(a)

Matters raised/discussed: WEPR; Steps to address staffing levels/care capacity and demand on ED nurses

Did you speak to an H & S Rep:

Did you speak to a Worker:

Did you speak to an H & S Rep:

Did you speak to a Worker:

Findings

Detail of All Findings: Observations/conclusions: Increasing demand/workload for Nelson hospital - often operating at 100% capacity (affecting patient flows including out of ED); escalation process for responding to increased demand not being utilised properly/in a timely manner; currently no tool for data capture/validation of workload within ED; pool of nurses to respond to increasing demand not always available to relieve increased demand in ED; nurses activating e-text to contact staff to come in early/or interrupting annual leave; breaks not being managed effectively resulting in breaks not being taken until 7 plus hours into shift

Resulting psychosocial harm i.e. short notice requests for change of shift impact on work life balance - also feeling obligated to work overtime/concern re impacts on other commitments; fatigue from long hours/lack of breaks/interruptions to down time when not at work; poor morale/stress re inability to provide adequate level of care to patients due to capacity/resulting in nurses fearful of loss of registration (complaints/investigations of complaints re mistakes/level of care)

WEPR processes - poor communication/transparency re response to issues raised and lack of timely feedback/response to issues raised through Safety First electronic incident reporting, by HSR and through HSC meetings; HS Management Committee - poor response to to issues raised, perceived criticism by HS Management Committee members for HSR raising issues; ineffective resolution process; apparent breakdown in communication/trust between NMDHB/staff/NZNO

Steps taken by NMDHB to address staffing levels/demands and capacity deficits: NMDHB has trialled and opened Medical Assessment Preadmission Unit (MAPU), this went 24/7 on 28/7/19; MAPU adds another 10 beds and is aimed at reducing demand on ED and other wards (preadmission); reviews to be carried out monthly on effectiveness; MAPU staff are under the Charge Nurse manager ED direction

Proposal for extension of Mental Health Patient Support person to cover Mon-Sun

Health Care Assistant (HCA) positions created to perform tasks which have previously been carried out by nurses (to free up nurses to do their more technical functions) reviewing additional tasks that could be performed by HCA with support of education/training package around this

NMDHB to pilot Trendcare implementation in ED

Process of management of e-text with proposed recommendation that this occurs from Duty Nurse Manager

Nurses requested to manage break times by writing up proposed break times at start of shift and managing this (emergencies excepted)

Action: Met with HSR & NZNO organisor to understand issues and background. Follow up meeting with representatives of NMDHB (accompanied by Annette Baxter GI Manager) to understand issues and background. Concluded that NMDHB is taking steps to ensure that staffing levels in ED/demand on nurses and capacity issues are addressed so far as reasonable practicable - PIN cancelled; Also concluded that NMDHB's processes and procedures to engage with workers, including the processes to provide information and feedback to workers on issues raised are inadequate - IN issued with recommended remediation to review and implement enchanced resolution process in consultation with HSR, including agreed timeframes/protocols for responding to issues raised (Safety First, HSC and HSRs) and review of makeup/function/protocols of HS management committee

Follow up meeting with NZNO and 9(2)(a) unavailable) to issue PIN cancellation and discuss reasons and IN; follow up meeting with NMDHB to issue PIN cancellation letter and discuss reasons and issue IN

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Assessment Re-Visit Required: No

Health & Safety Issues Found: Actionable Issues Identified

Hazard Management System:

Other focus area issues found: Other Priority Area > Secondary Focus Area > WEPR, Other Priority Area > Secondary Focus Area > Health & Safety Systems, Other Priority Area > Secondary Focus Area > Work Related Health > Occ Health - Other

Issues

Agency	Reason for Belief Of Issue	Nature of Issue	Issue Type	Notices
System	Conclusion after enquiries: NMDHB processes and procedures to engage with workers is inadequate The processes to communicate with workers, provide information and feedback on issues raised is inadequate	Conclusion after enquiries: NMDHB processes and procedures to engage with workers is inadequate The processes to communicate with workers, provide information and feedback on issues raised is inadequate	HSWA	HSWA Improvement Notice 21/08/2019 Nelson Marlborough District Health Board

Notices

Type: HSWA Improvement Notice

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Notes & Communications

Attachment	Type	Date	Description	Created By
e8c5f49e-11a5-4f22-b6b4-0f444a1843c2.pdf	Document	21/08/2019	SC notes from meeting with HSR & NZNO Organiser 30 Jul 19	Sue Cunningham
SC Notes from meeting with NMDHB 12 Aug 19.pdf	Document	21/08/2019	SC Notes from meeting with NMDHB 12 Aug 19	Sue Cunningham
AB notes from NMDHB meeting.pdf	Document	21/08/2019	AB notes from NMDHB meeting 12 Aug 19	Sue Cunningham
Findings.docx	Document	21/08/2019	Summary of meeting with HSR & NZNO on 30/07/2019	Sue Cunningham
0ae13aa5-d67a-4594-9829-8b93e8463501.pdf	Document	21/08/2019	SC notes summarising conclusion from review of PIN and NMDHB Worker engagement processes	Sue Cunningham
Cancellation of PIN sent to HSR.msg	Email	21/08/2019	Cancellation of PIN sent to HSR	Sue Cunningham
Email trail re appointment with 9(2)(a) .msg	Email	30/07/2019	Email trail re appointment with 9(2)(a)	Sue Cunningham
92d10b80-02b0-4d19-bfb5-c4adc5076530.msg	Email	26/07/2019	PIN Review request	Sue Cunningham
FW review of a PIN IN- E.msg	Email	26/07/2019	Acceptance of PIN review request	Sue Cunningham
Nelson Mail article on MAPU 27 July 19.pdf	Document	21/08/2019	Nelson Mail article re MAPU	Sue Cunningham
Copy of PIN.pdf	Document	21/08/2019	Copy of PIN	Sue

				Cunningham
1 VRM supplied by HSR.pdf	Document	21/08/2019	VRM supplied by HSR - document number 1	Sue Cunningham
e608fc07-481b-4c8c-9280-9467a88b6709.pdf	Document	21/08/2019	Recommendation letter sent to 9(2)(a) by HSR dated 11 May 2019 supplied by HSR - document number 2	Sue Cunningham
e7c20b7e-8347-430d-aadf-6ea45c148402.pdf	Document	21/08/2019	HR Business Partner Meeting Minutes 12 June 19 - supplied by HSR - document number 3	Sue Cunningham
9048633d-e07a-470a-a0d2-8f9815755dd6.pdf	Document	21/08/2019	NMDHB formal response letter to HSR dated 26 June 19 (supplied by HSR) - document number 4	Sue Cunningham
0eed58fa-0368-4df3-b605-cbb60459657a.pdf	Document	21/08/2019	Reply to formal response letter by HSR dated 3 July 19 (supplied by HSR - document number 5	Sue Cunningham
5 Attachment.pdf	Document	21/08/2019	Attachment to document number 5	Sue Cunningham
5 Attachment.pdf	Document	21/08/2019	Attachement to document number 5 (supplied by HSR)	Sue Cunningham
	Phone Call	21/08/2019	Call and return call to 9(2) 9(2)(a) and	Sue Cunningham

			9(2)(a) re cancellation of PIN and issue of IN and timeframe	
Cancellation of PIN & issue of IN to NMDHB.msg	Email	21/08/2019	Cancellation of PIN & issue of IN to NMDHB.	Sue Cunningham
Acknowlegement from CEO.msg	Email	21/08/2019	Acknowledgement of PIN cancellation and IN by NMDHB CEO	Sue Cunningham
c8d40e55-1c48-440d-9606-8bdcb4c30c2b.pdf	Document	21/08/2019	NZNO letter to NMDHB dated 26 July 19 (supplied by HSR) - document number 7	Sue Cunningham
4809b440-5064-4680-8bed-6dabb643c521.pdf	Document	21/08/2019	Monthly report to GM Clinical Services Oct 18 (supplied by HSR) document number 8	Sue Cunningham
c739c50f-c938-467d-a169-7293a13206b3.pdf	Document	21/08/2019	Acknowledgement of PIN dated 24 July 19 (supplied by HSR - document nuber 6	Sue Cunningham
Agenda for meeting supplied by NMDHB.pdf	Document	21/08/2019	Agenda for meeting with NMDHB (supplied by NMDHB)	Sue Cunningham
893eca77-fe3f-445c-ae79-beb70c842776.pdf	Document	21/08/2019	Update on progress against work in progress responding to HSR letter (supplied by NMDHB)	Sue Cunningham

3A Feedback on visit by 9(2) 9(2)(a) .pdf	Document	21/08/2019	Feedback on visit by 9(2)(a) (supplied by NMDHB)	Sue Cunningham
4A MAPU business case.pdf	Document	21/08/2019	MAPU business case (suppllied by NMDHB)	Sue Cunningham
5A Further information supplied by NMDHB.pdf	Document	21/08/2019	Further information supplied by NMDHB	Sue Cunningham

Attachments

File Name: e8c5f49e-11a5-4f22-b6b4-0f444a1843c2.pdf

Type: Document

Date: 21/08/2019

Description: SC notes from meeting with HSR & NZNO Organiser 30 Jul 19

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Reviews

Summary

Event	Date	Actioned By
File Document Added: 5A Further information supplied by NMDHB.pdf - Further information supplied by NMDHB	21/08/2019	Sue Cunningham
File Document Added: 4A MAPU business case.pdf - MAPU business case (suppllied by NMDHB)	21/08/2019	Sue Cunningham
File Document Added: 3A Feedback on visit by 9(2)(a) .pdf - Feedback on visit by 9(2)(a) (supplied by NMDHB)	21/08/2019	Sue Cunningham
File Document Added: 893eca77-fe3f-445c-ae79-beb70c842776.pdf - Update on progress against work in progress responding to HSR letter (suppl ...	21/08/2019	Sue Cunningham
File Document Added: Agenda for meeting supplied by NMDHB.pdf - Agenda for meeting with NMDHB (supplied by NMDHB)	21/08/2019	Sue Cunningham
File Document Added: c739c50f-c938-467d-a169-7293a13206b3.pdf - Acknowledgement of PIN dated 24 July 19 (supplied by HSR - document nuber 6	21/08/2019	Sue Cunningham
File Document Added: 4809b440-5064-4680-8bed-6dabb643c521.pdf - Monthly report to GM Clinical Services Oct 18 (supplied by HSR) document nu ...	21/08/2019	Sue Cunningham
File Document Added: c8d40e55-1c48-440d-9606-8bdcb4c30c2b.pdf - NZNO letter to NMDHB dated 26	21/08/2019	Sue Cunningham

July 19 (supplied by HSR) - document number 7		
Email Acknowledgement of PIN cancellation and IN by NMDHB CEO received from Nelson Marlborough District Health Board	21/08/2019	Sue Cunningham
File Document Added: 5 Attachment.pdf - Attachement to document number 5 (supplied by HSR)	21/08/2019	Sue Cunningham
File Document Added: 5 Attachment.pdf - Attachment to document number 5	21/08/2019	Sue Cunningham
File Document Added: 0eed58fa-0368-4df3-b605-cbb60459657a.pdf - Reply to formal response letter by HSR dated 3 July 19 (supplied by HSR - d ...	21/08/2019	Sue Cunningham
File Document Added: 9048633d-e07a-470a-a0d2-8f9815755dd6.pdf - NMDHB formal response letter to HSR dated 26 June 19 (supplied by HSR) - do ...	21/08/2019	Sue Cunningham
File Document Added: e7c20b7e-8347-430d-aadf-6ea45c148402.pdf - HR Business Partner Meeting Minutes 12 June 19 - supplied by HSR - document ...	21/08/2019	Sue Cunningham
File Document Added: e608fc07-481b-4c8c-9280-9467a88b6709.pdf - Recommendation letter sent to 9(2)(a) by HSR dated 11 May 2019 supplied ...	21/08/2019	Sue Cunningham
File Document Added: 1 VRM supplied by HSR.pdf - VRM supplied by HSR - document number 1	21/08/2019	Sue Cunningham
File Document Added: Copy of PIN.pdf - Copy of PIN	21/08/2019	Sue Cunningham

File Document Added: Nelson Mail article on MAPU 27 July 19.pdf - Nelson Mail article re MAPU	21/08/2019	Sue Cunningham
File Document Added: 0ae13aa5-d67a-4594-9829-8b93e8463501.pdf - SC notes summarising conclusion from review of PIN and NMDHB Worker engagem ...	21/08/2019	Sue Cunningham
Notice status changed to Issued	21/08/2019	Sue Cunningham
Party - 9(2)(a) - added	21/08/2019	Sue Cunningham
Email Cancellation of PIN & issue of IN to NMDHB. sent to Nelson Marlborough District Health Board	21/08/2019	Sue Cunningham
Phone Call Call and return call to 9(2)(a) and 9(2)(a) re cancellation of ... made to Nelson Marlborough District Health Board	21/08/2019	Sue Cunningham
Email Cancellation of PIN sent to HSR sent to Nelson Marlborough District Health Board	21/08/2019	Sue Cunningham
Notice status changed to Created	21/08/2019	Sue Cunningham
File Document Added: Findings.docx - Summary of meeting with HSR & NZNO on 30/07/2019	21/08/2019	Sue Cunningham
File Document Added: AB notes from NMDHB meeting.pdf - AB notes from NMDHB meeting 12 Aug 19	21/08/2019	Sue Cunningham
File Document Added: SC Notes from meeting with NMDHB 12 Aug 19.pdf - SC Notes from meeting with NMDHB 12 Aug 19	21/08/2019	Sue Cunningham
File Document Added: e8c5f49e-11a5-4f22-b6b4-0f444a1843c2.pdf - SC	21/08/2019	Sue Cunningham

notes from meeting with HSR & NZNO Organiser 30 Jul 19		
Assisting Workplace Assessment Visit	21/08/2019	Sue Cunningham
Assessment completed	21/08/2019	Sue Cunningham
HSWA Improvement Notice issued to Nelson Marlborough District Health Board under HSWA Section 58(1)	21/08/2019	Sue Cunningham
Party - Nelson Marlborough District Health Board - added	14/08/2019	Sue Cunningham
Status changed to Open	14/08/2019	Sue Cunningham
Status changed to Open	14/08/2019	Sue Cunningham
Assessment begins	14/08/2019	Sue Cunningham
Workplace Assessment Visit	12/08/2019	Sue Cunningham
Worker Engagement, Participation and Representation	30/07/2019	Sue Cunningham
Email Email trail re appointment with 9(2)(a) 9(2)(a) received from 9(2)(a) 9(2)(a)	30/07/2019	Sue Cunningham
Assessment initiated	26/07/2019	Sue Cunningham
Email PIN Review request received from Nelson Marlborough District Health Board	26/07/2019	Sue Cunningham
Email Acceptance of PIN review request sent to Nelson Marlborough District Health Board	26/07/2019	Sue Cunningham

Links

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EDM RECORD FORM - January 2018

File details

Duty holder: NMDHB | Date: 21/08/2019

Site/Premises: Nelson Hospital, Waimea Road, Nelson | File number: 5756812

01 Priority for Action

A brief description of the circumstances, including the specific issue and the expected benchmark/control:

Conclusion after enquiries:

NMDHB processes and procedures to engage with workers is inadequate

The processes to communicate with workers, provide information and feedback on issues raised is inadequate

Where there is no risk of harm, go to Step 4 below and use the Compliance/Admin fields (4b)

02 Risk Gap (including benchmark and actual risk)

Actual vs Benchmark Risk (tables 1.1 and 1.2)

Actual Risk	**Consequence**	Severe personal injury ☐	Significant injury ☐	Minor injury ☐	Nil ☐
	Likelihood	Probable ☐	Possible ☐	Remote ☐	Nil ☐
Benchmark Risk	**Consequence**	Severe personal injury ☐	Significant injury ☐	Minor injury/Nil ☐	
	Likelihood	Probable ☐	Possible ☐	Remote ☐	Nil/neg ☐
Risk gap (use table 1.1 or 1.2)	**Single/low casualties (1.1)**	Extreme ☐	Substantial ☐	Moderate ☐	Nominal ☐
	Multiple casualties (1.2)	Extreme ☐	Substantial ☐	Moderate ☐	Nominal ☐
		If Extreme/Substantial, go to Step 3		*If Moderate/Nominal, go to Step 4*	
				Nil risk gap ☐	

03 A Serious Risk from Imminent/Immediate Hazards? (s105 HSWA)

Is the Risk Gap Extreme or Substantial? Yes ☐ No ☐

Is there an immediate or imminent exposure to a hazard? Yes ☐ No ☐

Enforcement Action taken? No Action ☐ Prohibition Notice ☐ Sustained Compliance ☐

If you answered "No" to either question above, but issued a Prohibition Notice or Sustained Compliance letter, explain the other factors that influenced your decision at question 8.

Where a Prohibition Notice or Sustained Compliance letter was issued, consider an Improvement Notice for underlying causes and then continue to Step 5, applying flowchart 3.

04 Initial Enforcement Expectation

What guidance or standard did you apply: Section 58, HSWA

Status of standard (table 2) Defined ☒ Established ☐ Interpretive ☐

4a. Risk Matters

Initial Enforcement Expectation (table 3.1)

Consider prosecution ☐
Improvement Notice ☐
Directive letter ☐
Verbal direction ☐

Use 4a OR 4b

4b. Compliance/Administrative (Non-risk) Matters

Compliance/ administrative Descriptor (table 9)

Absent or never ☐
Inadequate or occasional ☒
Minor or short term lapse ☐

Initial Enforcement Expectation (table 3.2)

Consider prosecution ☐ Directive letter ☐
Improvement Notice ☒ Verbal direction ☐

05 Duty holder factors

Apply the applicable duty holder flowchart (flowcharts 3-6) and see the guidance for definitions

Is there a relevant compliance history?			Yes ☐		No ☒	
What's the level of actual harm?			Severe or Significant ☐		Minor or Nil ☒	
Is the duty holder deliberately seeking an economic advantage?			Yes ☐		No ☒	
Are vulnerable people put at risk?			Yes ☐		No ☒	
What is the overall standard of the management of health and safety?	Good ☐		Reasonable ☒		Poor ☐	
Does the Inspector's assessment of the duty holder give confidence the duty holder can and will comply?	Confident ☐		Some confidence ☒		Little or no confidence ☐	
Is it an infringement offence?			Yes ☐		No ☒	

Final enforcement expectation after considering duty holder factors (all that apply)

Consider prosecution ☐	Improvement Notice ☒	Directive letter ☐
Infringement Notice ☐	Prohibition Notice (or Sustained Compliance) ☐	Verbal direction ☐

06 Level, focus, and overall impact of enforcement

Does the overall enforcement approach:

• **Accord with WorkSafe's Prosecution Policy and Enforcement Policy?**	Yes ☒	No ☐
• **Take account of the scale of the failures and provide a proportionate response?**	Yes ☒	No ☐
• **Deal with the most serious risks in order of priority and in appropriate time scales?**	Yes ☒	No ☐
• **Adequately address the underlying problems and common causation factors?**	Yes ☒	No ☐
• **Secure sustained compliance?**	Yes ☒	No ☐
• **Influence and deter other duty holders in the same industry?**	Yes ☒	No ☐
• **Is there any other reason the level, focus and overall impact of enforcement is inappropriate?**	Yes ☐	No ☒

7. Final enforcement decision

Consider prosecution ☐	Improvement Notice ☒	Directive letter ☐
Infringement Notice ☐	Prohibition Notice (or Sustained Compliance) ☐	Verbal direction ☐

8. When the Final enforcement decision is different from the final enforcement expectation: What action did you take? What factors influenced your decision?

9. Any other comments?

Name of manager who approved final decision (if any):

Annette Baxter

Provisional improvement notice (PIN)

This Provisional Improvement Notice (PIN) is issued by a Health and Safety Representative (HSR) under section 69 of the Health and Safety at Work Act 2015 (the Act). This PIN requires the duty holder to whom it is issued to remedy a contravention, prevent a likely contravention, or remedy the things or activities causing contravention or likely contravention of the Act or regulations. Section 76 of the Act requires that the person to whom a PIN is issued must, as soon as practicable, display a copy of the PIN in a prominent place at, or near, the workplace or part of the workplace at which work is being carried out that is affected by the PIN. See the reverse of this form for further information about PINs.

Health and Safety Representative

Name: 9(2)(a) 9(2)(a)

Work group: Emergency Dept Nelson

Contact number: [redacted]

PIN issued to

Name of duty holder:

Nelson Marlborough DHB.

Address:

Private Bag 18
Nelson
7010.

PIN given to

(if the PIN is given to someone on behalf of the duty holder)

9(2)(a)

Details of contravention

Site location: Emergency Dept Nelson

I, 9(2)(a) (issuing HSR's first name)

reasonably believe that you:

are contravening, or are likely to contravene Shaun

Health and Safety at Work Act 2015, section 36

or

Health and Safety at Work Act 2015 Regulations

(specify which regulations)

Regulation date Regulation/s number

Brief description of how the provision is being, or is likely to be, contravened:

Failure to ensure, as far as it is reasonably practical, the health and safety of emergency dept nurses, through sustained sub optimal safe staffing levels.

Brief description of recommendations to remedy or prevent contravention:

Note: The HSR may, but is not required to,

- recommend measures to remedy the contravention or prevent the likely contravention, or
- make recommendations about matters or activities causing the contravention or likely contravention.

Recommendation attached - sent to 9(2)(a) 9(2)(a). 12/5/19 - and 3/7/19

Date PIN issued: 19 / 7 / 2019.

Date compliance with PIN is required: 25 / 7 / 2019. 3/7/2019
(minimum of 8 days after PIN issue)

Signature of HSR:
9(2)(a)

Annette Baxter

From: Annette Baxter
Sent: Friday, 26 July 2019 4:20 p.m.
To: Sue Cunningham
Subject: FW: Nelson Marlborough District Health Board Emergency Department PIN [IN-]
Attachments: Revisted PIN ED 24-07-19.pdf; Pin letter to worksafe 26-07-19.pdf; PIN review request 26-07-19.pdf

Categories: Red Category

As discussed - thanks

Annette

From: 9(2)(a)
Sent: Friday, 26 July 2019 3:42 p.m.
To: WorkSafe - Nelson Office <Nelson@worksafe.govt.nz>
Cc: Adam Watson <Adam.Watson@worksafe.govt.nz>; David Worsfold <David.Worsfold@worksafe.govt.nz>; 9(2)(a) 9(2) 9(2)(a)
Subject: Nelson Marlborough District Health Board Emergency Department PIN

Dear Sir/Madam

Attached are 3 documents relating to a PIN that we request Worksafe review.

- Completed PIN notice from HSR
- NMDHB letter requesting a review
- Completed Request an Internal Review of a Decision

Feel free to contact myself of the named parties from Duncan Cotterill Lawyers.

Kindest Regards

9(2)(a)

9(2)(a)

TE WAIORA Nelson Marlborough Health

Fax: (03) 546 1811
Phone: (03) 546 1999

Private Bag 18
Nelson, New Zealand

26 July 2019

WorkSafe New Zealand
PO Box 165
Wellington 6140

Attention: Nelson Office
By email: nelson@worksafe.govt.nz

To whom it may concern

Request for review – section 79 Health and Safety at Work Act 2015

We were served with the enclosed provisional improvement notice by email at close to midnight on 19 July 2019 from Health and Safety Representative 9(2)(a) We write with a request under section 79(1) of the Health and Safety at Work Act 2015 and ask WorkSafe to review the PIN on the following grounds:

1. the notice is defective in that 9(2)(a) failed to consult with the DHB about the issue of the notice (section 69(3)); failed to specify with due particularity the manner in which section 36 is allegedly being breached; and it provided only six days for NMDHB to comply with the PIN's recommendations.

2. the notice is substantively flawed in that the alleged breach is not properly particularised, nor capable of remedy in the manner required and in the timeframe specified.

The issue raised relates to allegedly sub-optimal staffing levels for emergency department nurses at Nelson Hospital. That is not accepted by the NMDHB. The issue of emergency department staffing is very complex and involves a multi-factorial approach. There is an ongoing dialogue about this issue. The NMDHB takes all steps so far as are reasonably practicable to ensure the health and safety of its patients and staff in the emergency department, and across the NMDHB, and to ensure that its workplace is without risks to the health and safety of its workers.

We made contact with 9(2)(a) on 24 July asking that she cancel the notice, or extend the timeframe to comply. 9(2)(a) was prepared to extend the timeframe to comply until 31 July 2019. However NMDHB consider the issue requires much more careful consideration than can be achieved in an additional six days.

This issue is extremely complex and staffing considerations across a hospital have to balance many factors. This is an issue that DHBs across the country face in best allocating the resources it has. In a nutshell adjusting staff numbers for one group of staff in one area can have negative and unforeseen impacts on another area which need to be carefully worked through and monitored.

NMDHB wishes to discuss this matter in person with a local inspector and proposes to write further to explain its processes around staffing, and will provide further information it requests is taken into account as part of this review process. NMDHB can provide that further information on or before 9 August 2019. Despite that the NMDHB welcomes the input of its H&S representative 9(2)(a) and is committed to ongoing dialogue with her.

Please note we are being assisted by Duncan Cotterill in Nelson on this matter, contact 9(2)(a)

9(2)(a)

REQUEST AN INTERNAL REVIEW OF A REVIEWABLE DECISION

WORKSAFE NEW ZEALAND | MAHI HAUMARU AOTEAROA

This request is made under Section 131 of the Health and Safety at Work Act 2015

Important: A review request must be made before the period specified in the Improvement Notice for compliance (if applicable), or 14 days; whichever is the lesser. In certain situations WorkSafe may accept this form after the periods specified above; contact WorkSafe for more information.

Your details

Are you making this request as a: (See the last page of this form for descriptions of these terms) ◉ PCBU ○ Worker ○ HSR ○ Other

Name of person requesting review: *(This could be an individual or a legal business name)* Nelson Marlborough District Health Board

New Zealand Business Number (NZBN): *(If applicable)*

9	4	2	9	0	0	0	0	9	8	0	2	1

Physical address: Braemar Campus, Waimea Road, Nelson South

Town/city: NELSON Postcode: 7010

Name of contact: *(If different to above)* 9(2)(a)

Phone number: Mobile number: 9(2)(a)

Email: 9(2)(a)

Details of the reviewable decision

Select the type of decision that this review request relates to:

Issue of Notice: ○ Improvement ○ Prohibition ○ Non-disturbance (or subsequent)

○ Extension of improvement notice compliance period ◉ Provisional Improvement Notice (PIN) review

Issuing Inspector: *(first name, last name)* Date of issue:

Provide a description of how you are affected by the decision, and why the decision should be reviewed:

Would you like WorkSafe to consider staying the original decision while its review is completed? ◉ Yes ○ No

☑ I have attached any additional information relating to why the decision should be reviewed; or why WorkSafe should consider staying the decision.

Health and Safety Representative (HSR) details

There is an HSR working for this organisation ☑ They are NZQA qualified to use their powers ☑

Declaration

☑ I declare that to the best of my knowledge, the information provided in this request is true and correct.

Name: *(first name, last name)* 9(2)(a) Date: 26/7/19

Note: the above declaration is considered to be an electronic signature that is reliable as appropriate for the purpose of this notification

Annette Baxter

From: Annette Baxter
Sent: Friday, 26 July 2019 4:33 p.m.
To: Sue Cunningham
Subject: FW: review of a PIN [IN]

FYI and file

From: Annette Baxter
Sent: Friday, 26 July 2019 4:31 p.m.
To9(2)(a)
Subject: review of a PIN [UNCLASSIFIED]

Good afternoor9(2 Thanks for your notification to review the PIN issued to you in regards to the emergency department. This is to let you know that we have received your notification and I have allocated this work to an inspector, Sue Cunningham. Sue will be in touch with you next week. In the meantime we confirm we will stay the notice until the review is complete.

Ngā mihi

Annette Baxter
Manager,General Inspectorate
Nelson Marlborough

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Getting you home healthy and safe.
That's what we're working for.

30/7/19
13:30 hrs

Nelson Meeting Room 1
with 9(2)(a) HSR NMDHB
and 9(2)(a) NZ Nurses Organisation (NZNO) — Union for Nurses and professional body.

Demand in Emergency Department increasing (monthly report showing stretch on Department) however over last 7 months four ED nurse positions lost (plus another mental health nurse position not available Mon-Fri.) Originally funded through govt funding post Kaikoura Earthquake

After Nurses strike July 2018 additional position from xmas — 30 June 6pm - 6am 7 days — now also gone.

Staffing diminished against increasing need.

Shifts day, afternoon night for rostered 8 hours

Nurses are being coerced into working overtime — have an escalation pathway ie nurse duty nurse. Sometimes results in assistance from another ward but more often than not no one available. Some casuals — but generally already scheduled and working to their max.

Text system to make requests to permanent staff not already working — "can you come now" often sent very late/early — sent to people on days off.

By coerced means worker feel they can not leave because there is no one to hand patient on to.

Note - Nurses have a "duty of care" ie ethical obligation to stay with their patient until they have someone to hand onto. Nurses consistently working without breaks — particularly on night shift (or day/afternoon & have a relieved who can relieve for nurses to take breaks).

Most days overtime worked in ED — eg. 240 times in 239 days (over 3 shifts — ie at least once in 24 hour period) particularly afternoon & night shift.

During day shift — other nurses available (eg nurse educators) sometimes (limited) to step in and assist with immediate need

Impacting on work life balance; ability for nurses to bounce back — often dealing with stressful events.

Unsupported — eg nurse dealing with sudden death of critically unwell patient under her care — no opportunity to take break/debrief — expected to carry on with next patient — no time/opportunity

Team supportive — but no structure to support

Mantle — people saying I can't do this anymore.

High accumulation of leave because people unable to take — then forced to take/short staffed. Apart from leave already booked, no leave available between 1 March - November
Limited security presence in ED — 4-5 nights a week 9pm - 5am (Orderlies who have done training in de-escalating) — often don't have required number of nurses for certain situations requiring more than 1 nurse. eg resuscitation (need 3), escorts out of ED to higher level of care (can't take patient to another area because not enough cleaning in ED - another nurse already out), (Duress points for calling alarm to telephonist — need police etc.)
Short notice requests for change of shifts eg start early.
Nurses have monthly nurses meeting. Nurses raise issues on agenda — concerns re "overcrowding", aggression, unreasonable workloads.
Nurses fear for registration — fear put in situation where they make a mistake or they felt they have made a mistake & patient died and felt responsible.
Patient hung themselves in ED (not successful by seconds)
Nurse requested a review but ~~was~~ not done Safety First — categorised 1-5 (1&2 critical) goes to CEO & reviewed by Clinical

governance — put in 2 - SI event Downgraded to 3 or more — as "no harm" so not reviewed.
High attrition rate - will increase (anecdotely nurses are actively looking for work elsewhere. Senior Doctor has stated to 9(2)(a) "this is the worst H&S culture I have ever worked in"
If a nurse, a mistake that harms or potentially harm a patient — they can where a patient/family has made a complaint — are investigated by Health & Disability Commissioner — lack of support in some cases from DHB/managers. Anyone (nurses/doctors member of public) can make a complaint to Nursing Council
"Safety first" electronic reporting of incidents — anything from patient falling out of bed, actual or incident or near misses.
Filters depending on what incident as to who SI goes to
Encouraged to report — report Manager escalates
No feedback (other than thank you for reporting) x direct
Two monthly HSR committee meetings — good commitment from H&S — not management (absenteism/apologies; very slow resolution. No feedback on what is being done over issues raised by SI.
Result in reluctance to report due to lack of action

9(2)(a) 9(2)(a)

New 9(2)(a)

H&S management meeting – higher level Managers – lack of accountability or ownership/understanding of issues/their responsibilities
This is attended by HSR Committee chairperson (9(2)(a) is chairperson of clinical group)
The culture of the meetings/Senior Mgt is poor eg: (hierarchy/whittling) ill preparation by management – eg no response to requests for email) update, feedback – not much gets achieved – but lots of meetings
On paper, there is an Escalation process/for resolution – not adhered to.
Consultation – HSR Committee meetings & H&S Management meetings have been used to raise issues these issues over a number of years, but more formally and specially since August 2018. 9(2)(a) has put together documented recommendations – with lack of response/understanding In May 2019 9(2)(a) made specific recommendations and me

* In March 2018 HSR requested that they use powers under HSWA to escalate issues – reported to the then HS Manager – who said she had "unfiltered" H&S meeting with CEO.

* first prior to Nurses Strike told by Director of Nursing & Midwifery

"work was in progress with expected improvements to staffing" referring work with CCDM.
CCDM is model to match nurses/patients to workload (care capacity demand mgmt) ie care of patient require – nursing hours
see (1) May 19 Minimum VRM status showing Critical/Significant Capacity deficit
In good faith decision made not to proceed under HSWA.
Positions devolved (reduced capacity) – no contingency in place and no plans to review for at least 2 years ex. some departments have planned reviews between now & 2021 – ED doesn't even feature
In May 2019 9(2)(a) (as ED rep) made recommendations to (2) 9(2)(a) – (Associate Director of 9(2)(a) /Ops Mgr – Nelson Hospital) 9(2)(a) To address unsafe staffing in ED was called to meeting with HR, Mgr Mental Health & Addiction, 9(2)(a) , Bare Capacity demand mgr, ED Manager 9(2)(a) . (see minutes of meeting (3)
Deceased MARY (see Raes release) which was scheduled to open & thought to reduce pressure on ED 9(2)(a) asked for a review of effectiveness after 4 weeks 9(2)(a) was told she would be given a written response around her recommendations within a week

after (9(2)(a) had already a delay between making recommendation and the meeting — ie seemed to be protracted delay/unreasonable.
It took 6 weeks for a response — they accidently sent a 9(2)(a) which was sent in error — asked to disregard.
A second response received on 28/6/19. see (4). Response to recommendation dont address immediate staffing levels/ concerns.
9(2)(a) met (with 9(2)(a) EDmgr) & HR & PS Advisor — to ensure no delays - and to give a letter reiterating recommendations and seeking assurance on concrete action (see (5))
9(2)(a) made an appointment for 2 weeks time to see 9(2)(a) to issue PIN if no action — hoping this wouldnt be needed.
The day before the scheduled meeting — 9(2)(a) received an email from 9(2)(a) cancelling meeting stating she needed to seek advice from 9(2)(a) (HSE WMgr)
9(2)(a) asked 3 times for meeting to be rescheduled - declined.
9(2)(a) (NZNO rep/organiser) intervened - tried to get meeting rescheduled - declined. 9(2)(a) said to 9(2)(a) that 9(2)(a) joined meet with HSE Mgr in interim — this was Thursday. 9(2)(a) stayed

on after shift (0830hrs) to write PIN — misinterpreted "at least 8 days" framed to remedy as "within 8 days". dated 18th 19/7/19 sent via mail on 18/7/19. 2nd 1/2
The following Wednesday 9(2)(a) was in a trauma day outside of ED and 9(2)(a) came to see her at 1520hrs requesting that 9(2)(a) meet with 9(2)(a) at 1600hrs — note training (which included assessment) not scheduled to finish until 1630hrs 9(2)(a) excused herself early and waited outside 9(2)(a) office at 1618 hrs went to find 9(2)(a) PA and went to 9(2)(a) office.
present.
9(2)(a) letter requesting she cancel PIN and stating that PIN contravened Act.
9(2)(a) was not prepared to cancel PIN but on request from 9(2)(a) extended remedial compliance date until 31/7/19.
9(2)(a) spoke about the circumstances of the meeting and 9(2)(a) sent a letter to DHB — covered issues with circumstances of meeting, consultation, coercion (see (7))
Example of Monthly Report by ED Nurse Manager to GM Clinical Services, 9(2)(a) Oct 2018 - (see (8))
9(2)(a) is an elected HSR - goes to meetings in her own time (said ie put on timesheet but is not doing

rostered shift ie additional hours.
9(2)(a) has been HSR since 2014
initial training in Aug 2013
(elected Rep then did training)
Completed Transitional Training
by 'Worksafe Reps' in March 2017
Facilitator June Hoddle
Complete HSR Stage 2 8/7/19
- Van Schaik H & S Solutions 9(2)(a)
facilitator
Useful people to talk to for
a 'balanced' view;
Doctor 9(2)(a) - ED Director
9(2)(a) - ED Manager
9(2)(a) - Chairperson of college
of emergency nurses 9(2)(a)
NZNO - - Professional
nursing advisor / Nurse advisor
to college of emergency nurses.
NZNO - has 52,000 members
& represents nurses (over 75%
nationally) and over 90% DHB
nurses.
9(2)(a)
9(2)(a) - 0800 28 38 48

9(2)(a) no - away unavailable
19/8/17 - 17/9/19. Another HSR
ca 9(2)(a) 9(2)(a)
9(2)(a) to confirm
that Toni 9(2)(a)
Q's - learn
a copy of Request to review PIN
- to follow up/Check.
What likely outcome - discussed
if reasonable belief re ineffective
WEPR processes - IN
Note - framework worker participation

agreement in process of being
implemented - Canterbury, Westcoast
DHBs - (NZNO, PSA) and others
Recently agreed: 9(2)(a)
9(2)(a)

Meeting ended 1633 hrs

12/5/19

KS/SHRS Accompanied by Annette Sauter - NMDHB meeting re PIN Review & WEPR processes

9(2)(a) 9(2)(a)

9(2)(a)

9(2)(a) 9(2)(a)

9(2)(a)

- ryan mgr Clinical Services
- Gm HR.

Notes taken by Annette.

Findings:

Hospital capacity frequently 100%.

Issue re staff shortages not just ED plus no room to move patients when at full capacity.

NMDHB in 'red' for first time; already ~~Canadian~~ financing 17 positions, not funded for - need to do things differently to address demands (not just ED)

Funded (1.7m) MAPU - improving flow of medical patients.

Permanent Pool staff aligned to after hours to enable relief in ED

Renewing tasks for HEA & ESP in ED in addition to current tasks

MAPU & ICU staff respond to ED VRM Red

Pilot Trendcare ED - matching workload with demand.

WEPR - lack of effective resolution process

Lack of timely response to issues raised - Safety First (not always visible)

Local and HS meetings, HSR/HSC

HS Management Committee - make up, response - ineffective

ED nurses activated phone text/interrupt work/life balance

ED nurses need to manage break times (write up at start of shift & manage)

12.8.19

DHB meeting

General intro's - explained our role & why here

Background
- med size DHB
- lacks of funds
- strikes - tense environment
- 7250 staff - mix
- Lots of change of how things are done eg MAPU system & flow of patients started in July - 10 week trial.

- Putting in 2 nurse practitioners - still training (when?) - Nov
- putting in nurse assistances (1x in now) (when?)
- Communication 9(2)(a)
  - meets weekly with staff
  - at stage of how this gets into practice
  - ie is about to happen

Consultation - ED team meeting w/ staff around what nurse assistants can do, what training packages etc

CCDM -

Trend care - international tool that validates workforce against workload. methodology not yet desired.

How determine nursing levels now - when workloads more than staffing. → escalated use tool & determine level, then tells them what should be done.
eg who in hospital, pool staff, & who in the dept can cover ie increase their shifts.
? reactive

- Co-ordinators responsible - move patients around

Question around not enough staff to leave ED to help to other areas
- charge nurse to pick up coordinator role - some challenges in trying to get that to work.

Given document to show hrs given to ED from other areas of the hospital.
At times there is no one available → go to essential cares, difficult in a ED. Looking at what is causing this to happen.
Seasonal workload.
Starting to see impact from MAPU - see 2x documents provided.
Have had vacancies in ED - from middle of August will be fully staff. Recruited to full people leaving.
Have identified reasons why patients don't make it out of ED → effecting workload. Still need to look on responses of medical doctors to see patients.
Had an expert in to provide advice to keep up the patient flow (document provided). DCD
13 extra beds - 10 MAKU, 3 in surgical.
Review? mthly. First lot of data due out soon.
Coverage for shortages - roster on pool staff
(3.8) report to duty nurse manager to be allocated to area that is required.
VRN - variance response mgt (3.4)
casual pool - 15 x (RNs & health care assistance) ED has own casual staff. Permanent pool are skilled, have been orientated, where possible.
PSH - how is this managed?
- going to do a wellness survey
- incidents have been notified - talking individually about how they feel
- hard to get facts - eg sick leave rates
- "being resilient"
-

As ED have own casual pool & found they are called back in when on leave & day off. This shouldn't be happening. Are concerned about this.

Breaks - can work 7 1/2 without a break. Starting next week an extra resource person can cover for this. Process is to pre-write down when to take breaks so it can be planned. In ED there are times when this doesn't happen but shouldn't be the norm. Keen to fix this.

Met with staff last week around MAPU - asked about concerns & how work. Concerns included medical staff, process of moving patients (has been fixed) & vacancies.
Going back again in weeks - what's working, barriers, what can be done better.
How can staff raise concerns?
- reps
- committees
- concerns go on agenda
- meetings with NZNO reps
- safety first process - reports assessed every Friday, most serious first to prioritize, investigated eg 3x workload issues at ED over weekend. Take learnings - what can be done differently. Communicated back by - Lexie met with charge nurses
Found: - minuted staff meetings
- may be individually
- through safety first.
Is done today but may not meet everyone's needs.

Trialling new safety first re workloads - was to start 4 weeks ago, not yet in place.

Communication from H&S mgt committee hasn't been good - information not feeding through & recognised that the group didn't work. New new H&S manager in this to be improved. It was acknowledged & agreed. This is an issue.
Sending ED charge nurse to training on Tuesday &

will pilot it here. 1x of two areas piloting this.

Board & H&S committee members are trained in HSWA.

Security - trained in de-escalation. Reviewing to identify needs. In place now - 2x FTE.

Has been working with union through the process.

Put in extra shirts for cover. 1pm → ?
"D" Shirt.

21/8/19
0820hrs

Reviewed information provided by 9(2)(a) HSR) and NMDHB, and notebook notes taken by me and 9(2)(a) Annette Baxter from meetings with 9(2)(a) (NZNO Organiser) on the 30/7/19 and NMDHB on the 12/8/19 (PIN review request)
Conclusion after enquiries: NMDHB is taking steps to ensure staffing levels in the Emergency Department/demands on nurses and capacity issues are addressed so far as reasonably practicable
Action - cancellation of PIN
Conclusion after enquiries: NMDHB's processes and procedures to engage with workers, including the processes to provide information and feedback to workers on health & safety issues raised are inadequate.
Action - issue of IN 1.

Current situation ED

- Increased demand/workload
- Decreased nursing levels (disestablished Clinical Nursing Specialists (CNS) positions January 19 (originally funding for Drs in ED post Kaikoura earthquake – unable to fill so CNS positions instead; funded ended); RN 1.7 FTE position devolved 30/6/19 - these were additional ED nurse 8 hr/7 days positions to cover busy 'L Shift' created post nursing strike; plus loss of 1 mental health nurse position (not situated in ED but lots of support) previously available M-F)
- No validated Trendcare module for EDs in New Zealand; Care Capacity Demand Management (CCDM) – model to match nurses to workload/patients; part of this is Variance Response Management (VRM) system shows frequent Critical Care/Significant Care capacity deficit (often occurring outside business hours when there is limited capacity from other wards)
- Pool of casual nurses already scheduled to work/working at capacity
- Escalation pathway ineffective for hospital (Phone duty nurse, sometimes results in nurses from other wards – though often no one available; perception 'sort it, don't call again')
- Text system – requests sent to permanent staff not already working (to come in early or on days off)
- Redirection of suitable patients to Medical & Injury Centre - not an option/closed between 2130 & 0800)
- Planned reviews of Trendcare & CCDM in some wards but no indication of anticipated review/analysis of FTE in ED (first tranche – between now and 2021). Note – Nelson didn't have analysis part of variance management – required to report progress to MoH
- Lack of required number of nurses in ED at times for tasks e.g. resuscitation, observation of suicidal patient (not meeting national standards); insufficient nurses in ED to be able to release ED nurse to escort patient out of ED
- Some security presence (orderlies who have been trained in de-escalation techniques) – often not sufficient (aggressive/threatening patients); lack of support for orderlies (threatened)
- Medical Admissions Planning Unit (MAPU) – new unit opened 1 July 19. Purpose to ease pressure on ED by improving flow of patients; extra 10 hospital beds; pilot (Aug-Oct 18) showed reduced waiting time and overall stay in ED; First 4 weeks - Monday – Friday only. 24/7 from 29/7/19.
- Nurses consistently working without breaks (particularly on night shift)
- Nurses required to work long hours/overtime (particularly on night shift) – Nurses have an ethical obligation/duty of care to patients where they feel they can't leave on time if there is no one to hand their patient onto.

Impacts – Psychosocial Harm

- Short notice requests for change of shift impact on work-life balance/downtime and ability for nurses to bounce back from often stressful work situations
- Feeling obligated to work overtime and concern about resulting effects on other commitments outside of work
- Feeling unsupported e.g. inability to take break (due to lack of relief available) after death of patient
- Distress/stress re inability to provide adequate level of care to patients (due to staffing levels) and nurses fearful of loss of registration (and being subject of investigation of complaints re mistakes/level of care)
- Fear/stress re security issues/lack of adequate fosecurity to help deal with aggressive patients
- Fatigue from long hours/lack of breaks/interruptions to down time when not at work – can also lead to increased mistakes being made
- Poor morale – nurses frequently in tears, expressing feelings that they "can't do this anymore"
- High accumulation of leave/inability to take leave when wanted (due to minimum staffing level requirements); being forced to take leave and resulting impact/shortages in ED

Existing WEPR processes

- Elected HSR (for workgroups)
- HSC's (HSR grouped together to form HSC – 2 in Nelson Hospital, HS&W advisor, administrator to take minutes) – meet 2 monthly – good commitment from HSR - high absenteeism from management, very slow resolution of issues raised, poor feedback on what is being done as a result of Safety First reports
- 9(2)(a)
- HS Management Committee – (senior management with decision making ability, chairpersons of HSCs) meets 2 monthly (off months of HSC) – lack of accountability/ownership; lack of understanding of issues; lack of understanding of responsibilities (perception is that this is very hierarchical & issues raised criticised) 9(2)(a)
- Nurses monthly meeting – nurses can add to agenda and raise issues/concerns which is can be feed into HSC meeting

Reporting

Safety First – electronic reporting system for recording health & safety incidents/near misses – workers encourage to report but report; receive acknowledgement but poor feed-back about any outcome

ED Manager monthly report to GM Clinical Services – *Outcome/response to issues raised speck to* 9(2)(a)
Bi monthly Senior ED meeting (Senior doctors, nurses etc)
Minutes from HSC & HS Management Committee meeting

Consultation timeline

Issues relating to ED nursing levels raised through HSC meetings, HS Management meetings and letters of recommendation (4 letters of recommendation sent since August 2018)

11 May 2019 – letter of recommendation and raising concerns dated 11/5/19 sent by 9(2)(a) to 9(2)(a) – requesting response from NMDHB in 3 weeks – not received until 7 weeks later

6 June 2019 – meeting requested for this date by 9(2)(a) . Purpose of meeting to discuss concerns raised in letter of recommendation. Meeting attended by 9(2)(a) 9(2)(a) 9(2)(a)

6 June 2019 - meeting cancelled 10 minutes after start time as 9(2)(a) was not onsite and location of 9(2) not known.

16 June 2019 – rescheduled meeting held

28 June 2019 – NMDHB formally responded in writing to 9(2)(a) letter of recommendation dated 11 May 2019.

3 July 2019 – letter sent by 9(2)(a) in response and stating concerns raised re ED nurse staffing not addressed. Follow up meeting requested by 9(2) and scheduled for 18/7/19

17 July 2019 – meeting scheduled for 18th July cancelled by 9(2) stating she had yet to discuss letter with 9(2)(a) Requests by NZNO Organiser for meeting to be reinstated declined.

18/7/2019 (approximately 2330hrs) - PIN issued by 9(2)(a) (HSR ED Nurses) sent by email to 9(2)(a) 9(2)(a)), PIN dated 19/7/19, date to remedy 25/7/19.

24/7/2019 – 9(2)(a) attending assessed training. Approached by 9(2)(a) 9(2)(a) at 1520 hrs and asked to attend meeting with 9(2) at 1600hrs (note – training not scheduled to finish until 1630 hrs).

9(2) attended meeting – 9(2)(a) also present. 9(2) given letter requesting she cancel PIN and stating that PIN contravened. 9(2) said she was not prepared to cancel PIN, but extended due date for remedial action until 31/7/19 on request from 9(2)(a) .

26/7/2019 – Letter sent to 9(2)(a) from 9(2)(a) – upholding PIN and expressing concerns re tactics/response from NMDHB.

Annette Baxter

From: Sue Cunningham
Sent: Tuesday, 30 July 2019 8:20 a.m.
To: 9(2)(a)
Subject: RE: Meeting to discuss PIN and background [UNCLASSIFIED]

Hi 9(2)

That will be good to have your union organiser attend the meeting with you.

See you at 1.30.

Regards
Sue

From: 9(2)(a)
Sent: Tuesday, 30 July 2019 7:04 a.m.
To: Sue Cunningham <Sue.Cunningham@worksafe.govt.nz>
Subject: Re: Meeting to discuss PIN and background [UNCLASSIFIED]

Thank you Sue. I have asked my union organiser to attend, I have needed his support in some of the meetings I have had during this process. Thank you, 9(

Sent from my Huawei Mobile

-------- Original Message --------
Subject: Meeting to discuss PIN and background [UNCLASSIFIED]
From: Sue Cunningham
To: 9(2)(a)
CC:

Dear 9(2)

Further to my phone call to you earlier this afternoon, I would like to confirm our appointment at 1.30pm tomorrow at the Nelson Worksafe office (ground floor Monro Building at 186 Bridge Street, Nelson). The purpose of the meeting is to discuss the Provisional Improvement Notice issued by you to the NMDHB on the 19th July, and establish the background to this.

I look forward to meeting you tomorrow. In the meantime, if you have any questions in relation to the meeting, please feel free to contact me.

Thank you
Ngā mihi

Sue Cunningham

Health and Safety Inspector
General Inspectorate
Nelson Marlborough
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Annette Baxter

From: Sue Cunningham
Sent: Wednesday, 21 August 2019 12:08 p.m.
To: 9(2)(a)
Cc: 9(2)(a) Annette Baxter
Subject: Provisional Improvement Notice Review [UNCLASSIFIED]
Attachments: Cancellation of PIN - HSR letter.pdf

Dear 9(2)

I have completed my review of the Provisional Improvement Notice (PIN) issued to Nelson Marlborough District Health Board (NMDHB) by you on the 19th July 2019. This was the result of a PIN review request received by WorkSafe from NMDHB on the 26th July 2019.

The result of the review is that the PIN has been cancelled. Please see the attached letter confirming this and outlining the reasons for cancellation of the PIN. A similar letter has been sent to NMDHB.

I am continuing to engage with NMDHB in relation to their worker engagement processes.

I appreciate you are currently on leave. Please feel to contact me to discuss the review of the PIN at your convenience.

Ngā mihi

Sue Cunningham

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21 August 2019

9(2)(a)
, Emergency Department
Nelson Marlborough District Health Board

Cc 9(2)(a)

Dear 9(2) ,

Subject: Review of Provisional Improvement Notice (PIN) — Cancellation of PIN

This letter is about the PIN you issued on the 19th July 2019 to Nelson Marlborough District Health Board (NMDHB) for "Failure to ensure, as far as it is reasonably practical, the health and safety of emergency department nurses, through sustained sub optimal safe staffing levels".

I have reviewed this PIN under section 80 of the Health and Safety at Work Act 2015 (the Act). Information from both you and the recipient of the PIN has been taken into consideration.

I have decided to cancel this PIN, under section 81 of the Act, for the following reason:

- NMDHB is taking steps to ensure that staffing levels in the Emergency Department and demand on nurses/capacity issues are addressed so far as reasonably practicable

You are entitled under section 131 of the Act to seek a review of this decision. If you wish to do so, you must apply to WorkSafe within 14 days of receiving this notice. To do this, complete the 'Request an Internal Review of a Reviewable Decision' form located on our website.

If you have any queries, please contact me.

Yours sincerely,

Sue Cunningham
Health and Safety Inspector
WorkSafe New Zealand
DDI: 03 989 2963 | Mobile: 021 803 537 | www.worksafe.govt.nz
Email: sue.cunningham@worksafe.govt.nz

27/7/19

Unit eases pressure on hospital ED

Health

Samantha Gee
samantha.gee@stuff.co.nz

A new medical unit that aims to reduce pressure on the emergency department has opened at Nelson Hospital.

The 10-bed Medical Admissions Planning Unit (MAPU) opened on July 1, after a successful pilot programme last year.

Director of nursing and midwifery Pamela Kiesanowski said the purpose of the unit was to ease pressure on the emergency department by improving the flow of patients through the hospital. It was a dedicated space for assessing and observing patients with serious health conditions.

Some people were referred to the hospital by their GP and fast-tracked through the emergency department into the unit, she said. Other patients were admitted to the MAPU after going to the emergency department.

Kiesanowski said the change meant patients would receive intensive assessment and intervention sooner.

The unit was set up and trialled over 10 weeks in August and October last year. The trial resulted in reduced waiting time in the ED and reduced the overall length of stay for patients.

A survey of patients in the pilot found that most rated their care as "good" or "outstanding".

"It's early days yet," Kiesanowski said. "We do know the with pilot it took three to five weeks before we got real change in practice, but we are seeing that change already."

In the first week of the pilot, it took five days before someone was admitted, Kiesanowski said that on the day the new unit opened, there were people waiting at the door to come through from the emergency department.

She said for the first four weeks, MAPU would be open from Monday to Friday.

There were 15 positions created for the unit, some of which were filled by existing hospital staff. There is an associate charge nurse manager, 11 registered nurses, a pharmacy technician, a pharmacist, a social worker, an occupational therapist, and clerical support.

As the hospital now had an extra 10 beds, Kiesanowski said its capacity was no longer over 100 per cent on consecutive days.

"You can see it has put the staff in a better space."

(2)

11 May 2019

9(2)(a)
Associate Director of Nursing

Dear 9(2)(a)

Re: Emergency dept. Nelson. Nursing
"Recommendation under Schedule 2, clause 1 (f)". Health and Safety at Work Act

Details
Unsafe workloads in Nelson ED have increasingly been reported to senior nursing management through a variety of avenues (including: safety 1st, departmental meetings, NZNO, and health and safety meetings,). Despite the MECA 2018, nurses are repeatedly being required to endure very heavy and stressful workloads.

In the 7 months since 1 Sept 2018 until 16 April 2019, 239 shifts have been reported as VRM red and/or orange, with very limited or no resources available to assist under the VRM (variance response management) system. (See attachments).

The majority of these instances (VRM red/orange) occur outside business hours, and even with support from the CNM M-F 0700-1530, 83 day shifts needed extra staff. The least resourced shift is Saturday night. Afternoon shifts are consistently under resourced.

This data ***includes*** the shifts that were formerly reinforced by having a CNS, particularly weekend afternoons. The CNS positions were disestablished January 2019 and staffing is worse.

In addition, information in charts (attached) already submitted to you by 9(2) 9(2) demonstrate that we need 2 nurses more per 24 hr period.

CCMD scrutiny has commenced in Nelson, with some wards/depts. scheduled for FTE analysis. We have not been informed of an anticipated date for analysis of FTE in ED, but it is not in the first tranche.

In September 2018 in reply to my previous recommendation under schedule 2 you emailed that nurses should be "assured that nursing executive is strongly committed to addressing safe staffing" for the "identified areas under pressure and issues related to high workload demands on nursing".

Recommendation
CNS positions to be re-established as they were until January 2019.

In addition to this, a minimum 2 additional RN's are required 7 days per week. One RN should be rostered PM shift each day. One RN should be rostered N shift each day.

In addition to this, an additional RN is required on Saturday night shift (or 1745-0215 shift).

Within 3 weeks, please provide a plan of progress to increase base FTE as per this recommendation. **(Recommendation)**

Under Schedule 2, clause 10 (2), the PCBU, Person conducting a business or undertaking (hospital) must, within a reasonable time, respond to my request.

Can you please respond in writing within 3 weeks to advise us that you intend to provide the information, or if not please provide a written statement setting out the reasons for not providing the information.

Yours sincerely

9(2)(a)

H&S rep ED

Cc 9(2)(a)

Attachments –

1. Total required and actual nursing for 2017-18 FY and MAPU period
   ED average occupancy vs nursing ratios. 2 charts.

2. VRM red/orange by shift. This is taken from the daily shift reports completed by nurse coordinator in ED, please note that the night shift data corresponds to the day of the week when the majority of hours are worked. I.e. Sunday night on the chart is an actual Saturday night 2245hr start).

Can you please respond in writing within 2 weeks to advise us that you intend to provide the information, or if not please provide a written statement setting out the reasons for not providing the information.

Thank you

9(2)(a)

Health and safety rep

Emergency dept.

Nelson Hospital

Annette Baxter

From: Sue Cunningham
Sent: Wednesday, 21 August 2019 1:49 p.m.
To: 'peter.bramley@nmdhb.govt.nz'
Cc: 9(2)(a) ; Annette Baxter
Subject: Outcome of Provisional Improvement Notice review - Nelson Marlborough District Health Board [UNCLASSIFIED]
Attachments: Cancellation of PIN - Applicant letter.pdf; IN NMDHB.pdf

Dear Dr Bramley

I have completed my review of the Provisional Improvement Notice (PIN) issued to Nelson Marlborough District Health Board (NMDHB) by 9(2)(a) on the 19th July 2019.

The result of the review is that the PIN has been cancelled. Please see the attached letter confirming this and outlining the reasons for cancellation of the PIN. A similar letter has been sent to 9(2)(a) and copied to 9(2)(a) .

During the course of my enquiries whilst undertaking the review I concluded that NMDHB's processes and procedures to engage with workers, including the processes to provide information and feedback to workers on issues raised, are inadequate (the following provides a link to the Health and Safety at Work Act 2015 (HSWA) for your reference – refer to sections 58 – 60 for PCBU duties in relation to engagement with workers: http://legislation.govt.nz/act/public/2015/0070/latest/DLM5976660.html).

I have issued the attached Improvement Notice for NMDHB to address this matter. The notice outlines recommended steps to achieve compliance. Please note the due date for compliance with the Improvement Notice is the 30th January 2020. Please also note your review and appeal rights on the last page of the notice, together with a summary of the key provisions of HSWA in relation to notices. This includes the requirement to display the Improvement Notice at the workplace. (If you require an extension to the due date for compliance, please contact me prior to the 30th January, as I can only extend a notice prior to its expiry).

I have also provided a link to information on SafePlus, which you may find useful. SafePlus is a health and safety improvement toolkit for businesses and other organisations, and looks at three key elements of health and safety: leadership, risk management and worker engagement: https://worksafe.govt.nz/managing-health-and-safety/businesses/safeplus/.

If you wish to discuss any matter arising from this email, please feel free to contact me.

Ngā mihi

Sue Cunningham

Health and Safety Inspector
General Inspectorate
Nelson Marlborough
186 Bridge St, Ground Floor, Monro Building, Nelson 7010
P +64 3 989 2963
M +64 021 803 537
E sue.cunningham@worksafe.govt.nz
W www.worksafe.govt.nz

WORKSAFE
NEW ZEALAND | MAHI HAUMARU AOTEAROA

21 August 2019

Nelson Marlborough District Health Board
Braemar Campus,
Waimea Rd, Nelson South,
Nelson 7010

Attn: Peter Bramley

Dear Dr Bramley,

Subject: Review of Provisional Improvement Notice (PIN) — Cancellation of PIN

Thank you for your request to review the PIN, issued by 9(2)(a) on the 19th July 2019 for "Failure to ensure, as far as it is reasonably practical, the health and safety of emergency department nurses, through sustained sub optimal safe staffing levels".

I have reviewed this PIN under section 80 of the Health and Safety at Work Act 2015 (the Act). Information from both you and the issuing Health and Safety Representative has been taken into consideration.

I have decided to cancel this PIN, under section 81 of the Act, for the following reason(s):

- NMDHB is taking steps to ensure that staffing levels in the Emergency Department and demand on nurses/capacity issues are addressed so far as reasonably practicable

You are entitled under section 131 of the Act to seek a review of this decision. If you wish to do so, you must apply to WorkSafe within 14 days of receiving this notice. To do this, complete the 'Request an Internal Review of a Reviewable Decision' form located on our website.

If you have any queries, please contact me.

Yours sincerely,

Sue Cunningham
Health and Safety Inspector
WorkSafe New Zealand
DDI: 03 989 2963 | Mobile: 021 803 537 | www.worksafe.govt.nz
Email: sue.cunningham@worksafe.govt.nz

IMPROVEMENT NOTICE

WORKSAFE NEW ZEALAND | MAHI HAUMARU AOTEAROA

This notice is issued pursuant to sections 101 and 116 of the Health and Safety at Work Act 2015

Notice issued to: Nelson Marlborough District Health Board (NMDHB)

Address: Waimea Road, Nelson

Date of issue: Wednesday, 21 Aug 2019 Time: 1:35 p.m.

Details of person notice left with:

Name: Peter Bramley Position: CEO

Address: Braemar Campus, Waimea Rd, Nelson South, Nelson 7010

I, Sue Cunningham

Being an inspector appointed under section 163(1) of the Health and Safety at Work Act 2015 (the Act) reasonably believe that you,

*are contravening a provision of the Act or regulations made under the Act, or

~~*are likely to contravene a provision of the Act or regulations made under the Act~~ ~~(* tick as appropriate)~~

And require you to remedy this actual or likely contravention, or the things or activities causing or likely to cause a contravention.

Legislative provision being or likely to be contravened:

Health and Safety at Work Act 2015, Section 58(1)

How the legislative provision is being, or is likely to be, contravened:

Conclusion after enquiries:

NMDHB's processes and procedures to engage with workers, including the processes to provide information and feedback to workers on health and safety issues raised, are inadequate.

Recommended prevention or remedial measures:

In consultation with workers/HSR

- Review and implement timeframes/protocols for responding to and communicating the outcome of health and safety issues raised by workers (e.g. through Safety First Incident reporting, by HSCs and HSRs)
- Review and implement enhanced/agreed resolution process
- Review the effectiveness (makeup and function) of the HS management committee

Remedy required within period beginning on date of issue and ending on: 30/01/2020

Postal address: P O Box 180
Nelson

Inspector's signature:

Contact email: sue.cunningham@worksafe.govt.nz

A PERSON ISSUED WITH THIS NOTICE WHO FAILS TO COMPLY WITHIN THE PERIOD SPECIFIED COMMITS AN OFFENCE. A COPY OF THIS NOTICE MUST, AS SOON AS PRACTICABLE, BE DISPLAYED IN A PROMINENT PLACE AT OR NEAR THE WORKPLACE, OR PART OF THE WORKPLACE, AT WHICH WORK IS BEING CARRIED OUT THAT IS AFFECTED BY THE NOTICE. IT IS AN OFFENCE NOT TO DO SO, AND/OR TO INTENTIONALLY REMOVE, DESTROY, DAMAGE OR DEFACE THIS IMPROVEMENT NOTICE WHILE IT IS IN FORCE.

Information: If you wish to discuss the circumstances giving rise to this notice, in the first instance please contact the Inspector who issued the notice. It is important that you do this well before the end date of the compliance period stated above, if there are circumstances preventing you from complying with the notice as the failure to comply may result in prosecution. Any other queries or correspondence related to this notice should be addressed to the manager at the address shown above.

WORKSAFE NEW ZEALAND
PO Box 165, Wellington 6140 0800 030 040 www.worksafe.govt.nz

New Zealand Government

Review and Appeal Rights

A person affected by the decision of the inspector to issue this notice (or their representative) may apply to WorkSafe for internal review of the decision within the period specified for compliance with the notice, or 14 days after the day on which the decision first came to their notice, whichever is the lesser. The decision to issue the notice may also be appealed to a District Court on the grounds it is unreasonable, but only if it has first been reviewed by WorkSafe and WorkSafe has made a decision on the review.

If there is anything you do not understand about your review and appeal rights, you should consult a lawyer.

SUMMARY OF KEY PROVISIONS IN THE HEALTH AND SAFETY AT WORK ACT 2015

SECTION 101 POWER TO ISSUE IMPROVEMENT NOTICES

An inspector, who reasonably believes that any person is contravening, or is likely to contravene a provision of the Act or regulations, may issue a written notice requiring the person to remedy the contravention.

SECTION 103 COMPLIANCE WITH IMPROVEMENT NOTICES

It is an offence not to comply with this notice within the specified time frame. The penalty is a maximum fine upon conviction of $50,000 for an individual and $250,000 for any other person. However, it is not an offence to fail to comply with recommendations in an improvement notice.

SECTION 104 EXTENSION OF TIME FOR COMPLIANCE WITH AN IMPROVEMENT NOTICE

An inspector may, by written notice, extend the compliance period for the improvement notice. The inspector may extend the compliance period only if that period has not ended.

SECTION 114 WORKSAFE MAY VARY OR CANCEL NOTICE

Other than minor changes, a notice issued by an inspector may be varied or cancelled only by WorkSafe, not the inspector.

SECTION 117 DISPLAY OF NOTICE AT WORKPLACE BY PERSON ISSUED WITH NOTICE

A person to whom a notice is issued must, as soon as practicable, display a copy of that notice at or near the workplace, or part of the workplace, at which work is being carried out that is affected by the notice. It is an offence to fail to comply with this requirement, or to intentionally remove, destroy, damage, or deface a displayed notice while it is in force. The penalty is a maximum fine upon conviction of $5,000 for an individual and $25,000 for any other person.

SECTION 118 INSPECTOR MAY DISPLAY NOTICE

An inspector who issues this notice may, either before or after issuing the notice, display a copy of the notice in a prominent place at or near the workplace, or part of the workplace, at which work is being carried out that is affected by the notice.

SECTION 131 APPLICATION FOR INTERNAL REVIEW

Any person affected by an inspector's decision to issue an improvement notice or to extend the time to comply with it may, within the period specified in the notice for compliance or 14 days, whichever is the lesser, apply to WorkSafe for a review of the decision. The application must be made in the manner and form required by WorkSafe.

SECTION 134 STAY OF A REVIEWABLE DECISION ON INTERNAL REVIEW

If an application is made to WorkSafe for an internal review of a decision, WorkSafe may stay the operation of the decision at its own initiative or on application from the person that has applied for the review. If WorkSafe has not made a decision within 3 working days of receiving an application for a stay then WorkSafe is to be treated as having made a decision to grant the stay.

SECTION 135 APPLICATION FOR APPEAL

A person affected by an inspector's decision to issue a notice or to extend the time to comply with it may, if that decision has been reviewed by WorkSafe, appeal to a District Court against the decision on the grounds that it is unreasonable. The appeal must be lodged within 14 days after the day on which WorkSafe's decision on the review first came to the person's notice.

If WorkSafe varies or cancels the notice, a person affected by that decision may appeal to the District Court against it on the grounds that it is unreasonable. The appeal must be lodged within 14 days after the day on which WorkSafe's decision first came to the person's notice.

Note:

This notice does not exempt or temporarily relieve you from your legal obligations under the Health and Safety at Work Act 2015.

Annette Baxter

From: Peter Bramley <Peter.Bramley@nmdhb.govt.nz>
Sent: Wednesday, 21 August 2019 1:54 p.m.
To: Sue Cunningham
Cc: 9(2)(a)
Subject: RE: Outcome of Provisional Improvement Notice review - Nelson Marlborough District Health Board [UNCLASSIFIED]

Hi Sue

Thank you so much for your contribution to this process. Be assured we are committed to ensuring our staff have a safe and supported place to work as we wrestle with the daily demands of delivering health care to our community

Regards

Peter

Peter Bramley, Chief Executive, Nelson Marlborough
Private Bag 18, Nelson 7042, New Zealand 9(2)(a)

Please consider the environment before printing this email

From: Sue Cunningham [mailto:Sue.Cunningham@worksafe.govt.nz]
Sent: Wednesday, 21 August 2019 1:49 PM
To: Peter Bramley <Peter.Bramley@nmdhb.govt.nz>
Cc: 9(2)(a) Annette Baxter <Annette.Baxter@worksafe.govt.nz>
Subject: Outcome of Provisional Improvement Notice review - Nelson Marlborough District Health Board [UNCLASSIFIED]

Dear Dr Bramley

I have completed my review of the Provisional Improvement Notice (PIN) issued to Nelson Marlborough District Health Board (NMDHB) by 9(2)(a) on the 19th July 2019.

The result of the review is that the PIN has been cancelled. Please see the attached letter confirming this and outlining the reasons for cancellation of the PIN. A similar letter has been sent to 9(2)(a) and copied to 9(2)(a) 9(2)(a)

During the course of my enquiries whilst undertaking the review I concluded that NMDHB's processes and procedures to engage with workers, including the processes to provide information and feedback to workers on issues raised, are inadequate (the following provides a link to the Health and Safety at Work Act 2015 (HSWA) for your reference – refer to sections 58 – 60 for PCBU duties in relation to engagement with workers: http://legislation.govt.nz/act/public/2015/0070/latest/DLM5976660.html).

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If you wish to discuss any matter arising from this email, please feel free to contact me.

Ngā mihi

Sue Cunningham

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Attachment 2

TRANSFORMING CARE FOR THE ACUTELY UNWELL PATIENT.

PHASE 1 DELIVERY OF ACUTE UNPLANNED CARE

BUSINESS CASE FOR A MEDICAL ADMISSION AND PLANNING UNIT, NELSON HOSPITAL

20 March 2019

Contents

1. Approvals

Name	Position	Signature

2. Version History

Version	Description
0.1	Initial Draft modified from original business case
0.2	Revised draft incorporating feedback from executive review
0.3	Revised draft incorporating ELT feedback 9(2)(a) 9(2)(a)
0.4	Revised draft incorporating CE review – Peter Bramley
0.5	Revised draft incorporating clinical and operation management review – 9(2)(a)
0.6	Revised draft SMO clinical feedback – 9(2)(a)
0.7	Revised draft incorporating SMO clinical feedback – 9(2)(a)
0.8	Minor revisions incorporating CE review – Peter Bramley

3. Executive Summary

Being truly transformative means rethinking the way health care is organised and delivered. It means making continuous improvements to ensure integrated care is, and will remain, responsive to the health needs of our local communities. Modern medicine is evolving and moving from treating patients presenting with single organ problems (heart attack or stroke) to working with frail elderly patients with extensive medical problems. These undifferentiated complex presentations that are often more related to co-morbidity or ability to function independently than a single presenting problem.

Patients with an acute health crisis need to get to the correct care setting without delay, to get the treatment and care they need. Optimal hospital inpatient flow depends on early access to senior medical assessment and decision making, easy access to investigations and rapid to the correct care environment, such as a short-stay unit or specialty ward. The Medical Admissions and Planning Unit will enable this optimal flow.

When it is not readily clear what is causing them to be acutely unwell, it is challenging to quickly decide what, where and who is needed for effective treatment. Too often, patients with an unclear or undifferentiated presentation can wait unnecessarily long for diagnostic investigations and examinations. They can be in hospital Emergency Departments (ED) for extended periods while they wait for a hospital bed to become available to continue their assessment, treatment and care planning. Extended waiting and diagnostic uncertainty does little to alleviate their anxiety or that of their family and whānau.

Internationally and nationally, the modern model of care for assessment for patients with complex poly morbid health needs is responsive primary care with easy access to specialist assessment and advice in secondary care via an acute assessment unit that centralizes most acutely unwell patients (medical and surgical) in a single assessment area.

This new model of care based around a medically-led interdisciplinary team who were able to accept patients directly from ED for continued assessment and monitoring, early planning for a return to primary care and home was tested in July – September 2018.

A 10 week trial of a 10 bed Medical Admission and Planning Unit (MAPU) brought together specialist physicians, nurses and allied health professionals as an interdisciplinary team in a common ward environment to assess and treat those patients presenting to hospital with urgent undifferentiated health needs. The size of the unit was determined by floor space available in Nelson Hospital.

Centralisation of acute medical admissions close to the emergency department facilitated:

- Front line clinicians collaboratively working across a hot floor to develop solutions to reduce the impact on patients of having extended stays in the Emergency Department, and/or prolonged waits for hospital beds, or admissions to wards located away from their core care team.
- Allows prompt review of acutely unwell patients in their early stages of admission when they are most vulnerable
- Discharge planning from allied health at point of entry to help patients get back home sooner
- More efficient ward rounds for medical patients promoting early discharge and returning them home sooner.

The trial identified sufficient benefits for patients and health professionals in improving acute care patient flow through hospital to warrant the unit being established permanently.

This business case is for the establishment of a seven day a week Medical Admission and Planning Unit on Level 3, Nelson Hospital.

An investment of 9(2)(b)(ii) s sought to establish a MAPU at Nelson Hospital.

4. Context

4.1. Strategic Context

Nelson Marlborough Health (NMH) needs to be ready to respond to significant increases in demand for health care as a result of predicted growth in the size of our ageing population, most of whom are expected to live longer and with an associated increase in complexity of disease and ill-health. Our whole system response needs to ensure all sectors of our local health system are ready to respond and support the people of Nelson Marlborough to live well, stay well and be well.

The inter-connected nature of health care and the elements required to support the delivery of effective acute medical care can be found in Appendix One. The role of MAPU is highlighted in that diagram.

Health for Tomorrow (2016) and the Primary and Community Health Strategy (2017) articulate our vision for this future where people are key participants in maintaining optimal health, supported by extended and integrated primary care teams proactively addressing their routine health needs and specialist teams readily accessible when they experience episodes of acute ill-health.

As part of delivering these strategic visions, NMH has initiated a multi-year transformation Models of Care Programme designed to ensure patients get the health care they need at the right time, in the right setting and from the most appropriately skilled people. This transformation focus challenges patients, health professionals, management, administration and support staff to work as one system to make sure that health care is easy to access, joined up and cohesive across health and care settings.

4.2. Managing patients with acute health needs

Patients experiencing an episode of acute health need needs to get to the right care and treatment without delay. They need specialist examination or investigation to better determine where they need to be to get that care, and a clear plan to get them back home with minimal delay.

Traditionally this means presentation to hospital Emergency Departments, either directly or through advice and support to the person's home primary care team. After Emergency Department triage, some patients are then admitted into hospital for further investigation and management.

Often elderly patients, or those with co-morbid health conditions require more test and interdisciplinary input to formulate an appropriate treatment plan. Generally this may take longer than 6 hours – the ED treatment target. Furthermore, when the hospital is working to capacity and/or beyond, patients can experience delays getting to the right setting of care, or delays in getting home with the support they need to return to optimal health. The bottlenecks

can be manifest as extended stays in ED waiting for further investigation or waiting for a hospital bed to become available, which in turn impacts on ED's ability to respond to emergency demand.

Timeliness of response to acute health needs is critical in the health systems response to acutely unwell patients. New Zealand government's expectation (and target) is for 95% of patients to be admitted, discharged, or transferred from an emergency department (ED) within six hours of presenting[1]. This is seen a measure of efficiency of patient flow through hospital systems to get patients back home again. Shorter ED stays are associated with better outcomes. Nelson Hospital has consistently struggled to meet the six hour stay target (see 5.3 below)

Patients with acute medical needs are best managed by a medical team led by general physicians who have a breadth of knowledge and expertise in internal medicine. This can be direct management of patients, or by providing advice and support to general practice to continue managing their patients in the community setting. A central acute medical assessment services makes this a ready first point of access for specialist support and advice easier.

In Nelson Hospital medical care is centralised around the Medical Unit. However, there are delays in accessing interdisciplinary health teams and when the Medical Unit is at capacity, patients can end up being admitted onto wards less linked to the medical team they require, which compounds the problem. This distance from the care team they need is referred to as being "medical outliers". Being in an outlier bed means patients can end up staying longer in hospital, or being placed at increased risk of unanticipated adverse health outcomes.

The need to change the way acute care is delivered, particularly for those patients who require additional specialist investigation or additional review, is recognised by health professionals who have demonstrated strong willingness to improve care. It is recognised that a multi-stream solution is needed to ensure our health system is ready to respond.

[1] https://www.health.govt.nz/new-zealand-health-system/health-targets/about-health-targets/health-targets-shorter-stays-emergency-departments Accessed 06/03/2019

5. Background

Medical Admissions and Planning Units in hospitals have been shown to significantly improve hospital capacity to better manage acute presentations, reduce patient length of stay in hospital and decrease waiting time for patient transfers from ED to medical beds[2].

Most New Zealand District Health Boards have adopted short stay assessment units to manage acute care demands and report consistent improvement in hospital flow and integrated interdisciplinary team working. Nelson currently has 30 medical beds (see Table One below).

Table One: Comparison with other NZ District Health Boards

Medical Bed capacity	Assessment unit bed capacity	Staffing	Benefits
Taranaki DHB			
Have 60 medical beds, 45 are normally staffed but flex up to 50-55 for winter planning.	5 beds associated with their ED as short stay beds, ED is consultant staffed 24/7		
Hutt Valley DHB			
Have 48 staffed medical beds but flex to 54	16 beds (doubling of capacity from 8 bed AMU 5 years ago	Allied Health 5 days a week and an Early Supported Discharge Team. CNS gerontology is a critical element in their model	"It has changed the way our hospital operates, has allowed the medical unit to function efficiently. Defines everyone's business".
Southern DHB [Dunedin Hospital]			
46 General medical beds	8 beds in an Internal Medicine Admitting Unit (plan to increase to 20)		"Initially not a lot of difference, needs allied health otherwise you are wasting your breath", they have 2 FTE Allied Health, OT, Social Work and Physiotherapy.
Lakes DHB [Rotorua Hospital]			
40 general medicine beds	5 ED short stay beds and 5 beds in a Clinical Decision Making Unit.	Nursing comes jointly from ED and general medicine	The model has been in place since 08/16, "changed the way we deliver care", demand currently has gone through the roof.

[2] New South Wales Agency for Clinical Innovation 2014. NSW Medical Assessment Unit Model of Care Sydney ACI Acute Care Taskforce https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0008/247715/ACI14_NSW_Acute_Care_Model_of_Care_PUBLISHED.pdf

5.1. Case for change

Patients presenting to Nelson Hospital with an acute medical health condition often experience one or more of the following:

- extended stays in the Emergency Department for continued observation
- extended time in Emergency department waiting for radiological investigations
- delays in transfer to a hospital bed based on limited bed availability or availability of a ward team
- Increased risk as they are located away from the base medical and on-call teams
- admission into beds on wards other than the hospital's Medical Unit

"I had to put a patient with pneumonia in a corridor bed. There was no call bell, so I had to ask him to yell loudly if he wanted some help" ED Nurse (Safely 1st event log, 2019)

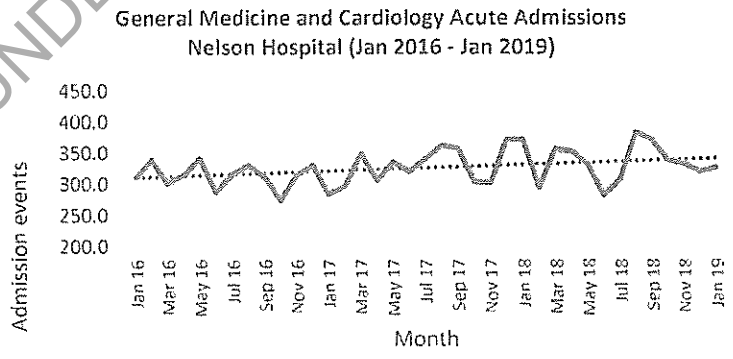
This leads to a sub-optimal experience for patients, and health professionals.

Short stay assessment medical facilities have been evidenced nationally and internationally to deliver improved hospital flow, shorter stays and more integrated care and discharge planning. In the UK, 90% of all hospitals have MAPU-like units.[3]

5.2. Nelson Hospital inpatient bed demand and capacity

There has been year on year growth in demand for hospital beds as evidenced by increasing volumes of acute adult medical admissions. Figure One below shows the volume of acute medical and cardiology admissions at Nelson Hospital has been trending upwards. Complexity adjusted length of stay is higher than the national average, potentially indicating reduced efficiency of the medical teams in the face of growing demand. All of these admissions are via ED.

Figure One: Number of acute medical and cardiology admissions to Nelson Hospital



The demand for inpatient medical beds is expected to continue to grow. Demand projections for hospital beds, based on bed day predictions from a 2017 baseline which

[3] https://www.nice.org.uk/guidance/ng94/evidence/24.assessment-through-acute-medical-units-pdf-172397464637

included right-sizing adjustments[4], show that, if no changes to models of care and/or hospital care delivery are made an additional 60 medical beds will be needed by 2037. The complete Nelson Hospital bed requirements are shown below in Table Two.

Table Two: Projected Hospital Bed demand for Nelson Hospital

Re-bases 2017 figures given current bed shortfall, with increases rising from the new base							Change from 2017 to 2037	
Nelson	Current	2017 adjusted	2022	2027	2032	2037	%	No of beds from current
Short stay unit	*5*	*15*	*17*	*19*	*21*	*23*	367%	18
ICU/CCU	*7*	*10*	*11*	*13*	*14*	*16*	124%	9
Med/surg	*84*	*89*	*102*	*115*	*127*	*139*	65%	55
Medical	*30*	*53*	*62*	*70*	*80*	*90*	200%	60
Surgical	*54*	*49*	*55*	*61*	*65*	*69*	28%	15
AT & R	*20*	*20*	*25*	*29*	*34*	*39*	96%	19
Subtotal	116	134	155	176	196	217	87%	101
Mental Health	32	31	32	32	32	31	-3%	-1
Neonatal	8	8	8	8	8	8	0%	0
Paediatrics	12	15	15	13	13	12	4%	0
Maternity	10	10	10	10	10	10	0%	0
Total	178	198	220	239	259	278	56%	100

							Change from 2017 to 2037	
Nelson	Current	2017	2022	2027	2032	2037	%	No of beds
ED	*5*	*5*	*5*	*5*	*6*	*6*	20%	*1*

Alexandra Hospital							Change from 2017 to 2037	
	Current	2017	2022	2027	2032	2037	%	No of beds
Total	12**	11	15	18	22	26	136%	15

Hospital bed occupancy is a measure of demand on hospital beds. Optimal occupancy rates are considered to be 85% or below by the Ministry of Health. The following graph shows the percentage of days per month when Nelson hospital, the Medical Unit and AT&R were at or exceeded 85% occupancy. Over the last two years, three quarters of ATR days and nearly 9 out every 10 days in MU are over at 85% occupancy or higher.

[4] Taken from Nelson Marlborough Health Clinical Services Plan and Indicative Business Case – Inpatient and Outpatient Demand Projections, December 2018, EY

Figure Two: Percentage of days per month when Nelson Hospital at >90% occupancy.

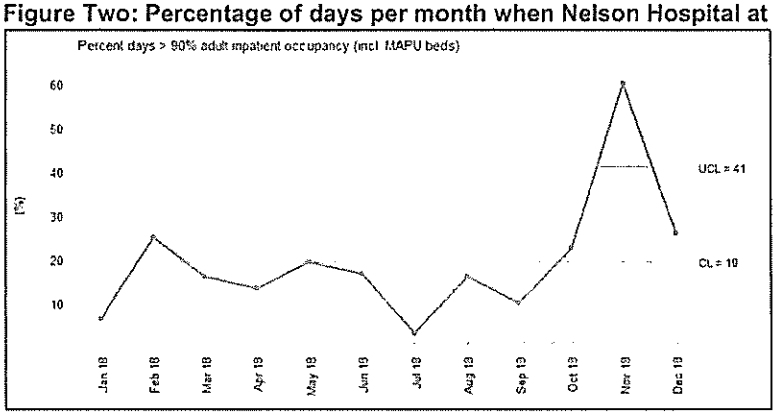


Figure Three: Percentage of days per month when Nelson Hospital Medical at >85% occupancy

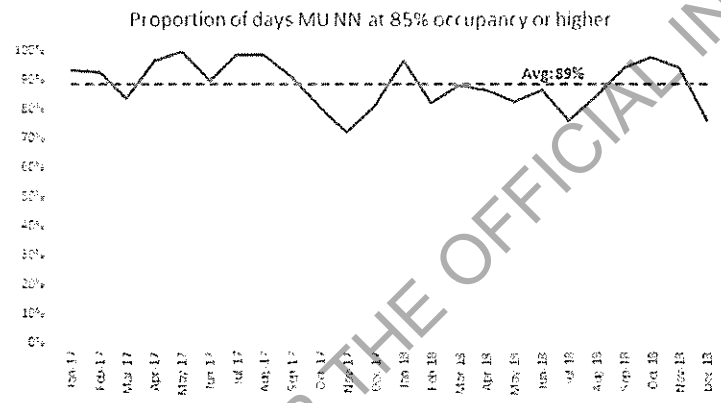
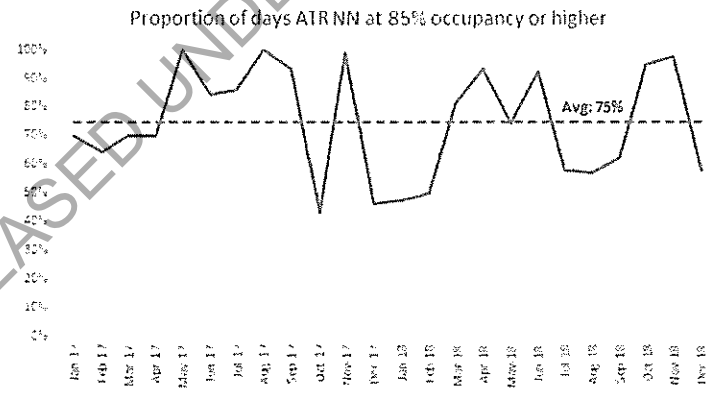


Figure Four: Percentage of days per month when Nelson Hospital AT&R at >85% occupancy

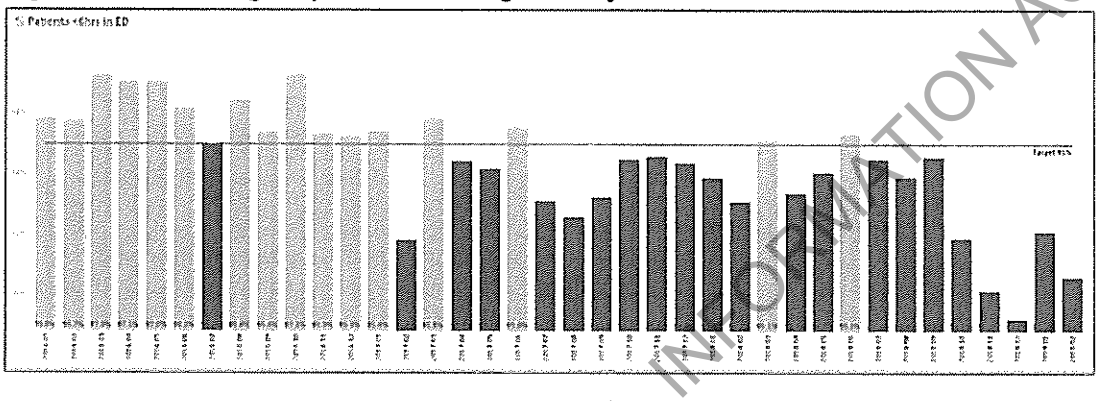


5.3. Extended stay in Emergency Department

As previously noted the national target for patients to be seen, treated and discharged from ED is within 6 hours of initial arrival. This has been repeatedly missed.

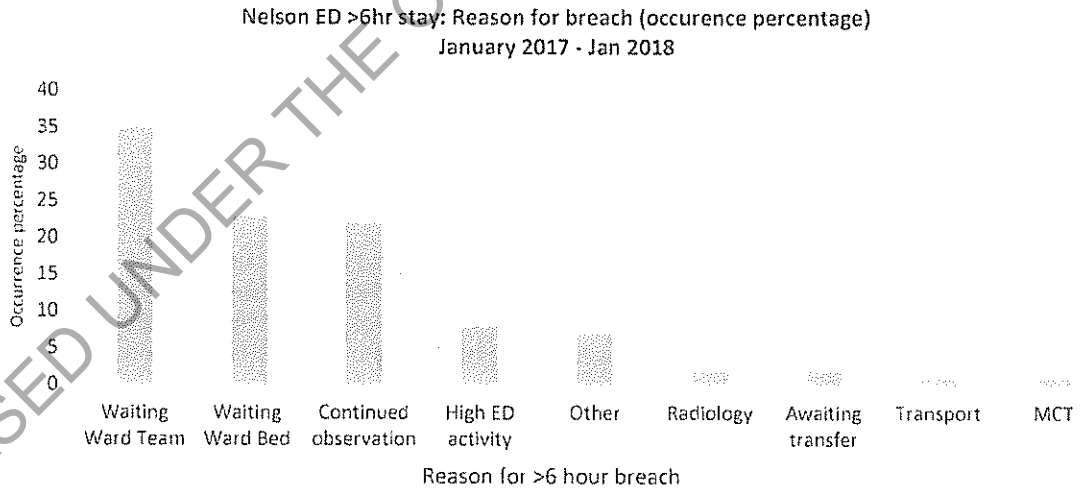
ED has experienced increased utilisation and congestion with difficulty meeting the 6 hour target. Since January 2017 ED Nelson has difficulty meeting the 95% of patients discharged from ED within 6 hours target.

Figure Five. Percentage of patients with length of stay in Nelson ED of less than 6 hours



A review of recent reasons for patients staying longer than 6 hours, since January 2017 showed 58% of patients remaining in ED for more than 6 hours were waiting either for the ward team or a ward bed.

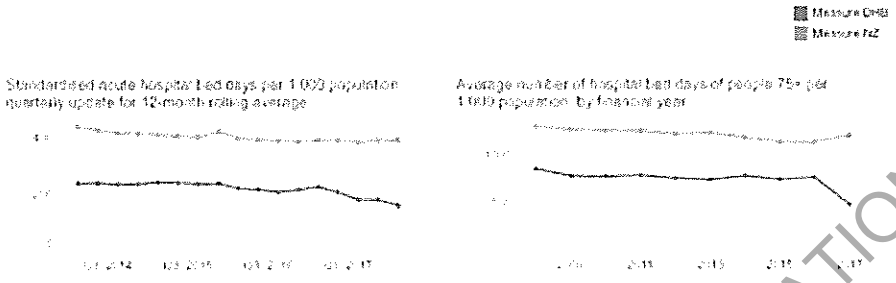
Figure Six. Breach reasons for patients presenting to Nelson ED and not being discharged from ED within 6 hours



5.4. Length of stay: Acute bed days per capita

According to Ministry of Health comparative performance data, Nelson Marlborough has the lowest acute bed days per capita of all DHBs nationwide, irrespective of ethnicity, deprivation or diagnoses. Amenable mortality rates show Nelson Marlborough is well below the national rate.[4] While there will undoubtedly remain opportunities to continue to reduce per capita acute bed day use over time, Nelson Marlborough's performance suggests improvement gains are likely to be insufficient alone to resolve pressure on acute secondary services.

Figure Seven: Comparison of Nelson Marlborough Acute Hospital bed days with rest of NZ



5.5. Medical outliers

Hospital medical bed occupancy has been increasing over time. This stretches hospital capacity for acute medical patients to be managed in the Medical Unit for the entirety of their hospital admission. When capacity is stretched, patients are generally admitted into, or transferred to the next available hospital bed which may be in surgical wards, paediatric, or on occasion maternity wards.

This geographical relocation distances them from their core care team which translates into longer length of stay, and introduces a degree of avoidable clinical risk and increased risk of mortality. The "safari ward round" where the core care team is taken away from the Medical Unit to deliver care, has become a daily hospital feature creating inefficiency in service delivery and variable outcomes for outlier patients.

Medical outliers have length of stay that is on average more than half a day longer than patients who remained in the Medical Unit with the same diagnoses and level of complexity.

6. Description of the MAPU Model of Care

A model of care to be delivered in the Medical Admission and Planning Unit (MAPU) was developed by an interdisciplinary project group of senior physicians, emergency specialists, senior nursing staff and allied health leadership in 2018. They were encouraged to design a model of care that benefited patient care. All clinicians embraced the transformation opportunity to challenge established practice, to become champions of change and to think across the whole of system.

MAPU is a dedicated stand-alone unit that is configured to accept patients presenting with an acute health condition directly. It provides a central operational space for effective interdisciplinary working. Centralisation of the medical process allows for improved efficiency in the medical teams with a streamlined admission process, and observation and assessment for patients with a predicted length of stay of 36 hours or less. This improvement in patient safety is key during the first 36 hours of illness when patients are at their most vulnerable.

Patients will be accepted into MAPU by the medical registrar or on-call physician after being assessed as appropriate for admission, following after an initial triage in the Emergency Department. There may be potential for referrals to be received directly from general practitioners in the future as the model of care evolves.

Having a medical registrar as part of the care team means collaborative, proactive identification of patients requiring MAPU care can be identified and moved earlier.

Once admitted to MAPU, patients have easy access to specialist physician assessment, further investigation, review and treatment planning without delay. This review will provide diagnostic and treatment clarity and allow patients to more rapidly access the treatment they need.

Access to pharmacists allows patients medications to be reviewed at admission and subject to medicine therapeutic review and reconciliation, and better coordination and oversight of discharge medications. This reduces the risk of unintended harm. Patients are also readily engaged with the Allied Health professionals who facilitate a safe and timely transition for the patient back to their home.

This simultaneous access to interdisciplinary nursing, allied health and medical team support on admission means discharge preparation, active rehabilitation to prevent physical de-conditioning and planning gets underway earlier. This translates into shorter hospital stays.

This business case supports the establishment of a 24 hour/7days Medical Admission and Planning Unit for Nelson Hospital. It is anticipated MAPU will improve efficiency in the admission process for unplanned patients by providing assessment, care and treatment for a designated period of up to 36 hours prior to transfer to the most appropriate hospital setting or home where appropriate. During the MAPU admission, discharge planning and allied health support will simultaneously be put in place. The unit will be physically located on Level 3 of the George Manson building, Nelson Hospital

The MAPU model of care aims to:

- Deliver a high quality, evidence based patient centered model of care for adult patients admitted with acute medical conditions
- Streamline the process of admission for non-critically ill medical patients with complex problems, close to the medical on-call team, including patients who present with conditions where a diagnosis is unclear.
- Expedite rapid and comprehensive multidisciplinary assessment of acute medical patients.
- Facilitate early consultant and/or medical registrar review
- Improve access to laboratory, radiology and other clinical investigative services.
- Improve links with general practitioner and community service providers.
- Enhance the capacity of ED as a consequence of the early transfer of non-critically ill undifferentiated medical patients from ED
- Reduce the need for outlier patients distributed in other areas separate from their hospital care team and eliminate the associated inefficiencies from misdistribution of admitted patients.
- Standardise care on the basis of agreed care protocols, procedures and guidelines.

6.1. Staffing required to deliver the model of care

The staffing matrix below has been developed based on the profile of patients who will be receiving care in the MAPU. Attention has been given to the high turnover and the undifferentiated nature of the medical patients who will receive services in the MAPU. Services will be delivered 24 hours a day, 7 days a week.

6.1.1. Nursing

To ensure round the clock care, MAPU will require the full-time equivalent of 9.8 nurses. There will be a lead nurse on each shift in MAPU, who will liaise with other departments on the hot floor, ED in particular.

6.1.2. Medical cover – RMO

The acute physician is on call physician for that day who takes a leadership role in the MAPU and provides a direct clinical contribution. No additional RMO capacity is required. Medical Registrars will primarily be based in MAPU during the day but float to ED pulling, treating and discharging patients.
The admitting house officer (supported by trainee intern when available) will be predominantly based in MAPU to undertake any clerking and instigate any investigations and treatments newly admitted patients may require

6.1.3. Allied Health

Allied health staff will be available to support early engagement in discharge planning and preparation. Early intervention will support patients to remain independent and will prevent the deconditioning associated with hospital bed rest. Allied Health Practitioners working with a transdisciplinary approach and framework will allow greater workforce flexibility and a focus on a skills sharing approach from the separate disciplines.

6.1.4. Pharmacy

Inclusion of pharmacy and pharmacy technician resource will allow medications reviews and reconciliations to support safe expedited discharge. Pharmacy provide education, medicine reconciliation and analysis of pharmaceutical influence on presentation and treatment aimed at rapid return to home and the community.

6.1.5. Clerical and Administrative support

Clerical Support process admission and discharges and provide administration support to enhance flow. An additional 1.54FTE administrative support will be required to support the model of care.

6.1.6. Hotel Services

With the high throughput additional cleaning and laundry support may be required. This will be over and above the current requirements of the Day Stay Unit.

7. MAPU pilot

In July – September 2018, a 10 week pilot of a 10 bed Medical Admission and Planning Unit (MAPU) was undertaken, using beds in the Day Stay Unit.

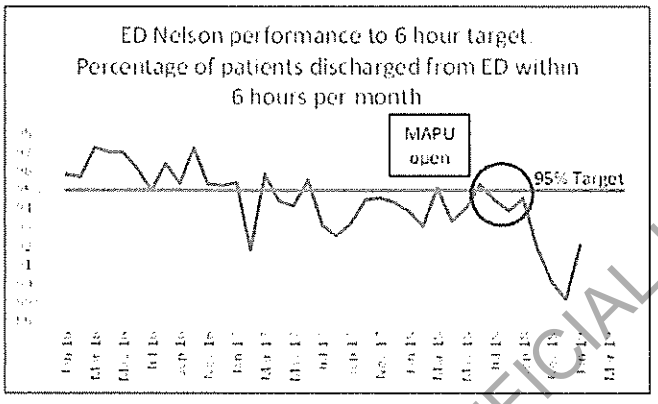
An evaluation of the impact of the MAPU pilot showed promising improvements in reduced patient length of stay in ED following an acute presentation, shorter lengths of stay

particularly for patients who are medical outliers, and improved interdisciplinary working. Staff responded positively to most aspects of the MAPU trial, and considered the changes to be valuable for efficient patient care and flow.

7.1. Length of Stay in ED

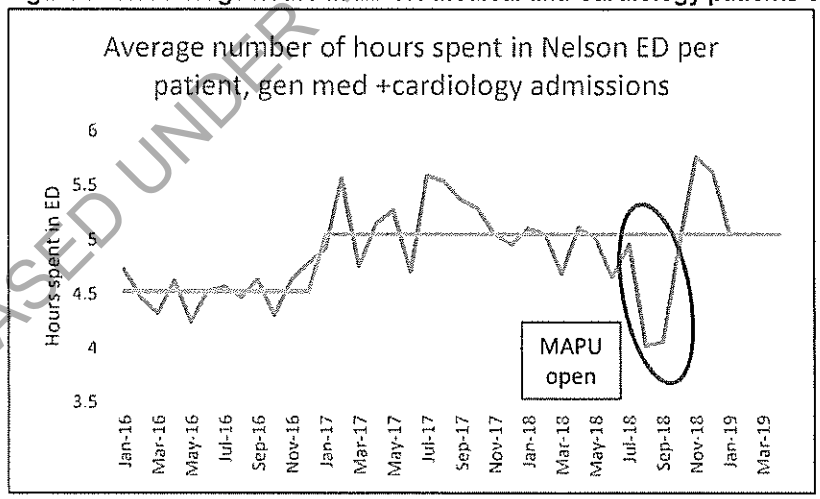
The MAPU pilot saw a flattening in the long-term decline of ED performance achieving the 6-hour target through 2018. However, once MAPU closed, the long-term performance decline continued.

Figure Eight: Nelson Emergency Department delivery of 6 hour stay (against 95% target)



Overall time in ED for all patients during the MAPU pilot did not definitively decline, although it appears to have been somewhat lower than the same period in the previous year. A decline in time in ED was however seen for those patients with an acute medical or cardiology presentation (see Figure Nine below).

Figure Nine: Average hours in ED for Medical and Cardiology patients only



7.2. Medical outliers

One of the clear impacts was on the number of outlier medical patients. There was an approximate halving of outlier days across Nelson Hospital during the peak medical admission time, which is a notable impact from MAPU for the system as a whole.

Figure Ten: Standardised rates of medical outliers

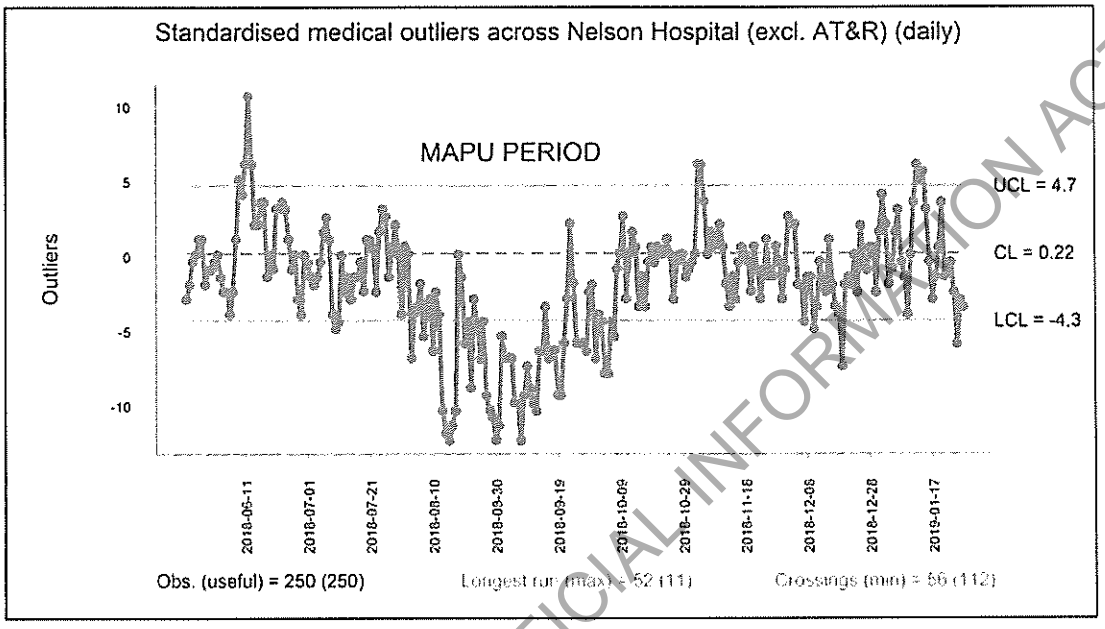
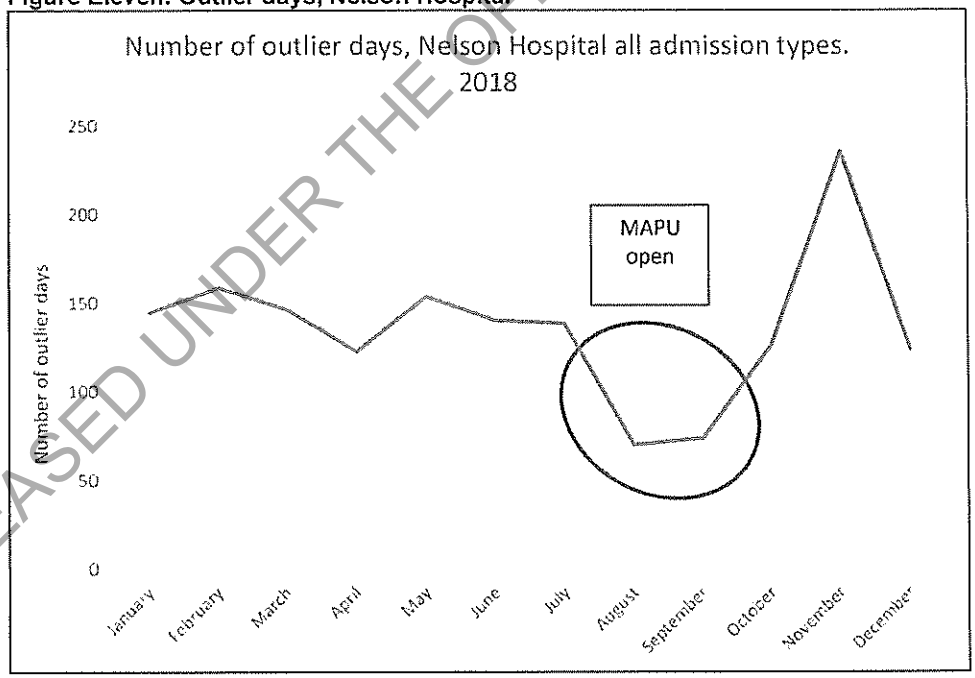


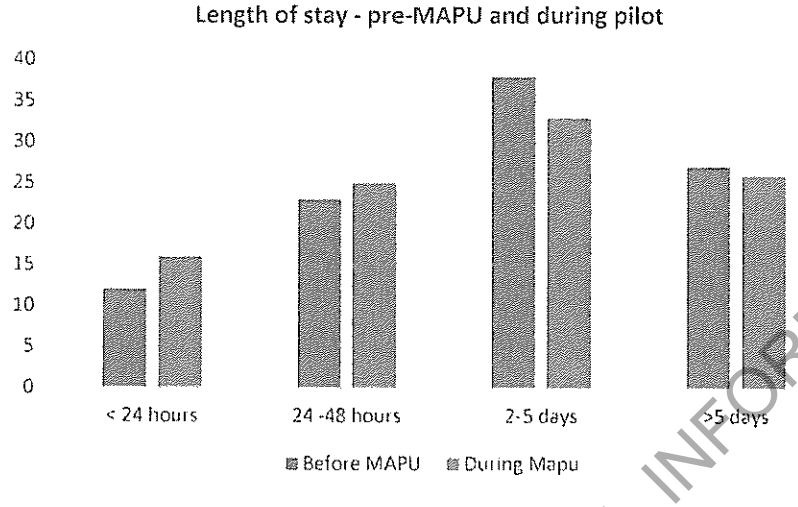
Figure Eleven: Outlier days, Nelson Hospital



7.3. Length of stay in hospital

A significant increase in the number of patients discharged within 24 hours for medical patients was seen during the MAPU trial. This supports the model of care assumptions.

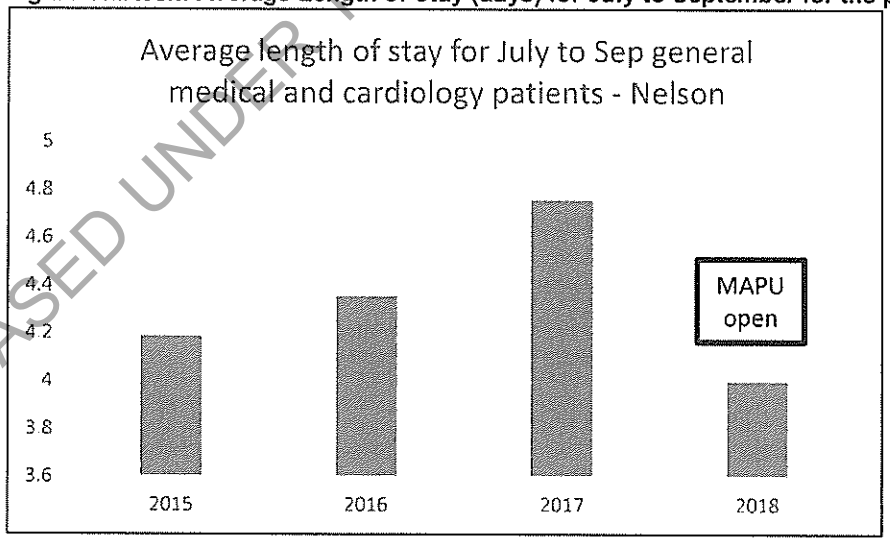
Figure Twelve: Comparison in average Length of Stay (LOS) before and during MAPU pilot



For stays 24 hours or less, decrease in average length of stay reached statistical significance (p=0.0001).

Average length of stay in days, of general medical and cardiology patients during the operation of the MAPUdropped by half a day over the three months. The reduction was more marked in August. The reduction in average length of stay was more pronounced with the same period of July – September over the preceding three years

Figure Thirteen: Average Length of Stay (days) for July to September for the past 4 years.



One of the risks of a shorter length of stay is that patients will end up being readmitted within 7 days of discharge, or will die shortly after discharge.There was no increase in the average percentage of people readmitted within 7 days during the operation of the MAPU, nor any change in mortality rates.

7.4. Interdisciplinary Allied Health team impact

During the MAPU trial, a seven day Allied Health service of Allied Health Practitioners – 2 Occupational Therapists (1.6 FTE) and a Social Worker (.2FTE) were recruited and provided 7 day cover. The Allied Health Practitioners worked to the Calderdale Framework of professional skill sharing, meaning they were able, with suitable accreditation, to also deliver physiotherapy services.

An integrated screening, assessment and management framework was applied that identified patient needs. The tool used during the MAPU pilot was successful in providing more comprehensive screening and resulted in more comprehensive referrals.

Staff feedback reported positive experience of the professional skill-sharing model, use of an integrated framework, early identification of patient needs and earlier supported discharge. There was highlighting of the benefit and value of working in interdisciplinary teams.

333 patients were assessed, 238 receiving full inter-disciplinary screens and approximately 50% of patients were discharged directly home, the other 50% were transferred to medical beds or directly to ATR.

The number of clinical tasks carried out by the Allied Health Practitioners that were professionally skill shared were purposely limited due to the fixed term nature of the project. If the service continued a further analysis and identification of other professional skill share clinical tasks would be beneficial.

There was some increased demand for hospital dietetics which appears to a consequence of more effective malnutrition screening. The trial did not appear to reduce or additionally burden other hospital allied health services.

An additional pharmacist and a pharmacy technician resource was made available during the pilot. This was provided by backfilling and releasing the pharmacist working in the Medical Unit. This resulted in better detection of medication errors at admission from medicines reconciliation. Centralisation of acutely unwell medical patients in one location meant the pharmacist was also able to monitor discharge medications to ensure quality and safety.

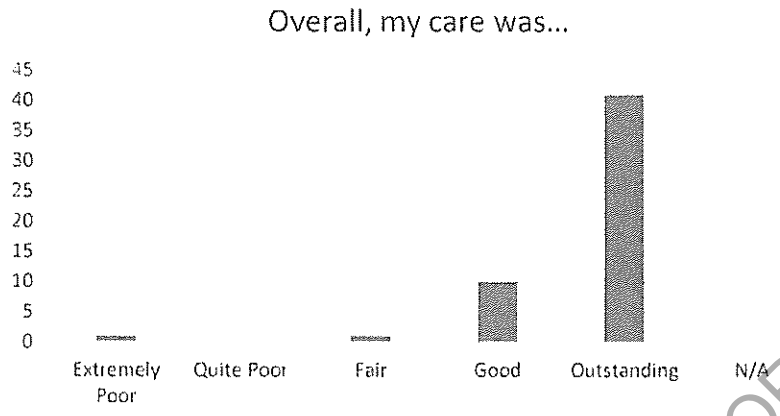
7.5. Staff and patient experience

MAPU made a positive difference to patient care. KPIs showing positive results included

- A reversal of the trend of an increasing length of stay of medical admissions.
- An improvement in time of discharge for medical patients,
- A reduction in the number of standardized medical outliers,
- A reduction in ED breaches,
- A reduction in time in ED for medical patients.

Patient feedback was positive with 77% of respondents rating their care in MAPU as outstanding.

Figure Fourteen: Patient satisfaction with MAPU care



Staff felt a permanent MAPU would be sustainable if:

- MAPU was adequately staffed
- Some parallel changes were started in medical rounds and,
- Any impacts on the regular functioning of Day Stay were mitigated.

7.6. Overall learning

The model of care for managing acutely unwell medical patients by delivering medical specialist-led care from a dedicated unit with ready access to medicines reconciliation, allied health assessment and planning improved the following over the 10 week trial:

- Patient flow through the hospital and to the care teams they needed.
- Patient safety (No adverse events were noted)
- Earlier access to allied health review and better planning for discharge
- Reduced length of stay in hospital, and the associated physical deconditioning experienced by patients during extended bed stay.
- Decongestion of ED which supported the capacity of the ED team to attend to new presentations and other emergencies
- Improvement in the ability to meet the ED 6 hour target.
- Preservation of a calmer atmosphere on the Medical Unit where longer stay patients with more complex conditions were accommodated.
- Improved bed management as better hospital flow reduces the need to reschedule surgery solely as a result of pressure for beds. The associated improved hospital bed management has a follow-on effect of reducing time taken from nursing and management staff to effect bed management.

Ready access to senior medical review allowed patients to be transferred to MAPU for continued assessment and monitoring. Improved links with RMOs allowed proactive identification in ED able to be "pulled" through to MAPU by dedicated RMO staff.

Patients return to home and primary care were better planned and delivered as a result of by early access to pharmacy review and allied health staff support. Interdisciplinary team working delivered over 7 days supported this improved planning and delivery. An exciting skill-sharing delivery model trialed by the Allied Health professionals reduced wait time delays for access to profession-specific allied health specialist services. Patient-centred action planning was able to be delivered,

Future directions
The pilot demonstrated that even with limited bed availability there were significant gains in patient flow.

Additional development of the acute care model in the future includes better integration of primary care support into the model with MAPU evolving from an admissions unit to an assessment unit for the better support of primary care.

Integration with acute surgical services into an assessment and planning unit offers further cross collaboration gains for better care of patients. However, much work is required to develop the model in light of the successful MAPU trial.

The model shows great potential for improving patient care and experience as well as smoothing hospital flow. There is a real opportunity for better collaboration across the hot floor for improve demand management.

Once embedded, there is scope to extend the MAPU admission process from a solely ED or hospital triage to direct admission of general practice referrals, and the evidence suggests that the models could be extended to include access to surgical support in treatment and care planning. The planned rebuild of Nelson Hospital will include sufficient floor space for an appropriately sized MAPU to be ready for delivery within the next 5-7 years. In the meantime, establishing MAPU now is the necessary precursor which will also resolve current demand and flow issues, and get patients readily to the treatment they need.

8. Scope

8.1. In Scope

- Adult patients presenting, or referred to, Nelson Hospital ED with undifferentiated medical conditions.
- Medical, nursing and allied health staff to deliver the MAPU model of care.
- Operational and capital resources

8.2. Out of Scope

- Acute paediatric patients, who already have access to rapid paediatric assessment and planning.
- Patients presenting with acute surgical conditions
- Intermediate care beds.

9. Business Drivers and Key Performance Indicators

9.1. Business Drivers

- Having a clinically robust response for acutely unwell medical patients.

9.2. System Key Performance Indicators

- 6 hour ED breach volumes and reasons
- Medical outlier volumes
- Mean and median length of stay within MAPU

9.3. MAPU specific Key performance indicators

The performance of the unit will be monitored using the following key performance indicators:

9.3.1. Patient/hospital flow: Efficiency gains in process; shorter stays for patients

- No (%) of all acute medical patients (including cardiology) presenting to ED who are admitted to MAPU.
- Length of time between ED request and patient arrival on MAPU.
- Length of time between admission and first consultant review
- Length of delay in transfer from MAPU after post bed request

9.3.2. MAPU admissions

- Number of discharges within 36hrs of admission
- Number of transfers to other wards within 36hrs of admission
- Mean and median length of stay
- Percentage of patients who received allied health assessments

9.3.3. Balancing measures: Ensuring no unintended adverse consequences

- Readmission rate within 30 days of discharge
- Percentage of patients suffering serious adverse events within the unit

9.3.4. Operational measures:

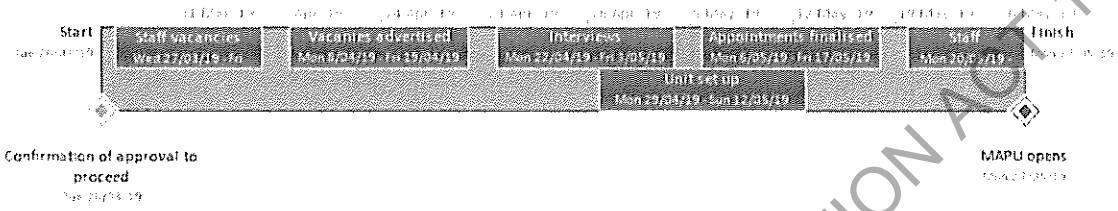
- Nursing hours utilized
- Budget under/overspend against budget, including staff overtime and absenteeism
- Staff turnover
- Number of days medical outliers per month

9.3.5. Patient Experience

- Patient and staff satisfaction (formal questionnaire and complaint review)

10. Time Frames

From approval to proceed, the plan is to have the MAPU open and ready in time to respond to the winter increase in presentations of acutely unwell medical process. As the physical space was set up during the pilot, the key time will be taken up with the recruitment and training. Taking this into account the MAPU would take 10 weeks to fully commission, subject to successful appointment being completed in one recruitment cycle.



11. Benefits

11.1. Tangible Benefits

- Streamlined access to appropriate treatment for non-critically medical patients with an acute health need.
- Better use of hospital beds with alignment of acuity and length of stay
- Improved hospital flow for patients with clinically appropriate shorter lengths of stay
- Reductions in casual and overtime expenditure
- Reduction in the requirement for additional daily bed planning meetings equating to a potential non-cash releasing efficiency gain of about $ 9(2)(b)(ii) as staff capacity likely to be absorbed by other activities.
- Emergency Department able to meet access target of discharge within 6 hours with additional ED capacity released. This benefit will be non-cash releasing efficiency gain.
- Reduction in frequency and duration of safari ward rounds. An average safari ward round to care for an average 17 medical outliers is estimated to cost 9(2)(b)(ii) per day. This will be a non-cash releasing efficiency gain.
- There will be a decrease in elective surgery cancelled on day of surgery in response to lack of hospital bed availability.

11.2. Intangible Benefits

11.2.1. Patients

- Patients receive faster access to the appropriate clinical care team and resources with a reduction in duplicate or multiple assessments being undertaken
- Earlier medical differentiation reduces the likelihood of unnecessary investigations.
- Shorter stays in hospital as a result of intense support will support improved patient flow
- Earlier detection and treatment resulting in early access to appropriate treatment

- Improved access to appropriate and timely care, including specialist and middle grade review out of hours due to the co-location of high acuity patients on the hot floor.
- Each patient receives intensive pharmacy support on admission and on discharge with medications review and reconciliation which reduces the likelihood of additional medication-related errors and harm.
- Comprehensive and early involvement of Allied Health professionals supports shorter stays and earlier discharge. As well as minimising the physical deconditioning associated with extended hospital bed rest, this promotes safer return home.
- Earlier discharge minimises risk for patient from being in an inpatient environment, such as hospital- acquired infections, falls and confusion.

11.2.2. Staff

- Co-location of the extended care team in a single clinical environment removes inefficiencies associated with bed reallocation and rearrangement of elective surgery.
- Improved work flows are expected to deliver improvement in staff morale, that if sustained flows on to support retention of staff, and attracting new staff.
- Improved risk management as a result of standardised management protocols and clinical handover involving ED staff and medical staff.
- Improved supervision opportunities for junior medical staff.

11.2.3. Nelson Marlborough Health system

- First phase and foundation for a new model of acute care demand management, aligned with changes in primary care response to acute and unplanned care arising from the uptake and spread of the Health Care Home framework.
- Foundation of acute demand management services to inform the rebuild of Nelson Hospital
- Supporting primary care through easier access to specialist advice from a medically staffed 24/7 service supports general practice to continue managing acutely unwell patients in the community, reduces pressure and demand on both ED and hospital beds.
- More comprehensive allied health assessment leads to expedited discharge to home
- Decreased numbers of medical outliers leads to increased quality of care by being closer to ward team
- Improved bed management with buffer bed capacity for acute medical patients at times of excess caseloads.

12. Costs

12.1. Tangible Costs

OPERATIONAL COSTS (OPEX)	9(2)(b)(ii)
Nursing	**FTE**
Clinical Coordinator (ACNM)	1.2
Registered Nurses	9.8
Nurse Educator	0.2
Pharmacy	**1.58**
Pharmacist	1.0
Pharmacy Technician	0.58
Allied Health	**3.0**
Allied Health Practitioner (OT &/or Physiotherapy)	1.6
Social Work	0.2
Allied Health Assistant	0.5
Administration	
Clerical support	1.54
	OPEX Subtotal

12.2. Intangible Costs

- Location of the MAPU necessitates a change in the model of care for the infusion services currently delivered by the DSU nursing team using this area. Note comments above re FTE changes in DSU.
- Long-term impact on staff of being called at short notice to respond to spikes in demand. This potentially erodes staff good will, reduces job satisfaction and could adversely impact on staff retention.

13. Risks and mitigations

Risk	Mitigation
• Changes required in other parts of the system do not occur result in MAPU having no impact on length of stay.	• Clear operating protocols with patients only admitted with accepting clinician. • During the day the Patient Flow Manager works with the MAPU coordinator to optimize patient flow. After hours Duty Nurse Manager provides this at other times.
• MAPU demand impacts on the ability of Day Stay Unit to operate	• Clear delineation of physical bed spaces with separate co-ordinator, management plans for these alternative units. • Review and reconfiguration of the DSU Model of Care
• Primary care refer inappropriate patients to speed up treatment access.	• Clear communication with general practice about scope and service offer of MAPU • Normal ED triage applies, consistent application of decision making about admission and close working between acute services and ED. • ED will be the single point of entry for acute medical admissions.
• Growth in demand may exceed predictions resulting in an under-supply of MAPU capacity	• Continued work on models of care is able to support greater numbers being cared for in environments other than acute hospital beds.
• Reduction in surge capacity for overflow beds, as DSU is currently being opened for overnight stays on a reactive basis to manage inflow.	• Changed model of care expected to deliver improved hospital flow, and reduce the need for overflow beds.

14. Assumptions

- System changes as a result of the Models of Care programme will support demand reduction, facilitated discharge and primary care management
- The current physical space at Nelson Hospital will be adequate to meet current and future demand.
- A permanent MAPU will deliver change at pace and scale.
- Early access to assessment, medical review and Allied Health support delivers benefits to acutely medical patients.

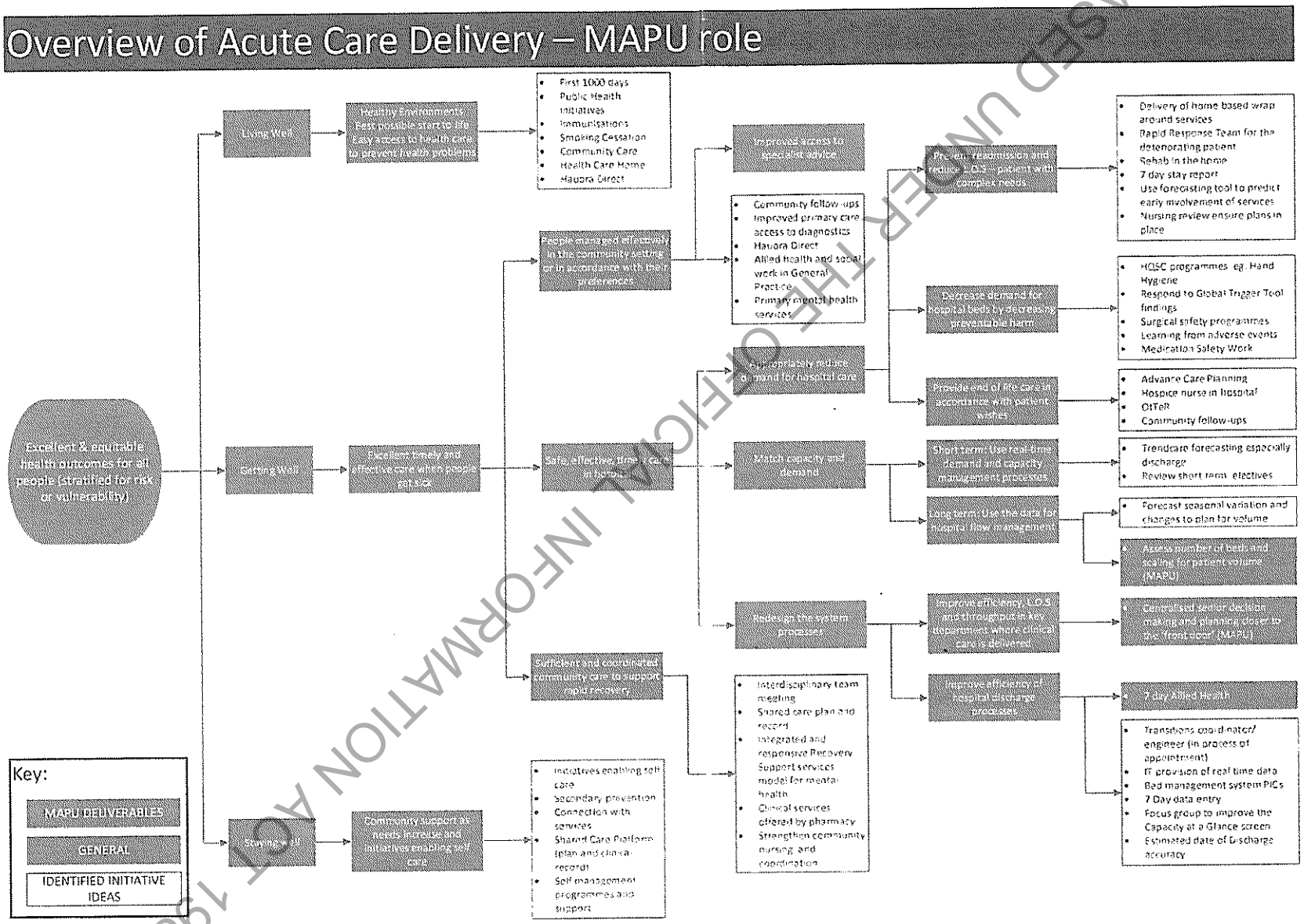
15. Project Rank

The project will provide significant efficiency gains and aligns with the Models of Care programme.

Table Three. Project rank descriptions

Category	Factor	Description
1	High Risk/Regulatory	Direct patient or staff risk Regulatory or industrial risk Mandated or regulatory requirements
2	**Strategic**	**Part of DHB or Information Strategy**
3	Strong Return	Payback period under 12 months
4	**Efficiency Gains**	**High degree of efficiency achievable - higher patient throughput for example**
5	General	General Project

APPENDIX ONE: OVERVIEW OF ACUTE DELIVERY



CCDM Funding and Fte Allocation

	FY19 Funding:	FY19 Actual Spend:
MOH - Notification	9(2)(b)(ii)	9(2)(b)(ii)
Balance Remaining:-		

Actual Spend by Ward/Unit

	FY19
Ward 9	9(2)(b)(ii)
Ward 10	
Medical Unit	
ED	
Nn: Resource/Response	
Wairau IPU	
District Nursing	

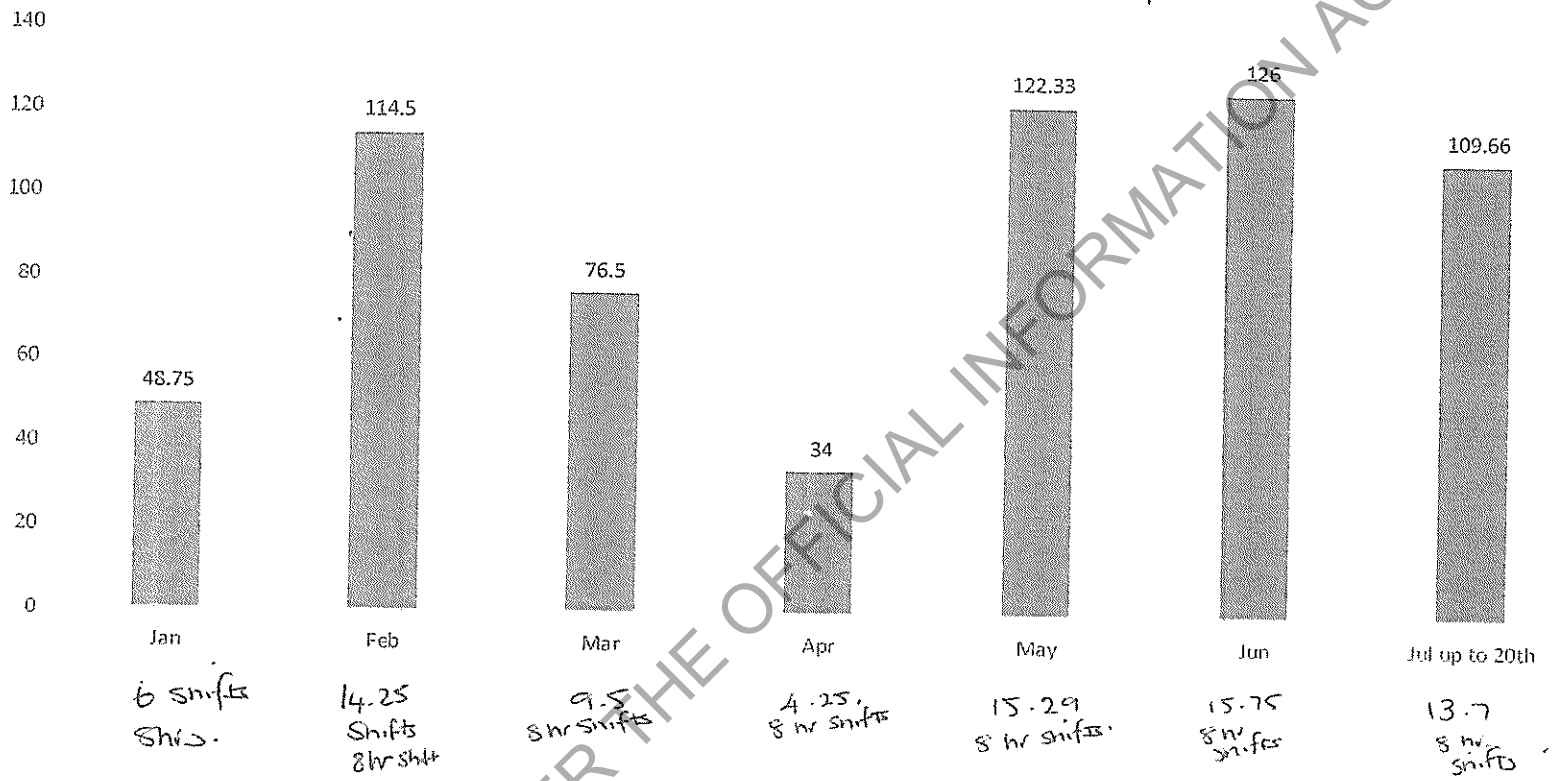
Proposed Budgeted Fte Allocation - FY20

	RNs	HCAs
Ward 9	1.7	
Ward 10	1.7	
MU	1.7	3.4
ED	-	1.7
Resource	3.4	
	8.5	5.1
Wr - IPU	1.2	
DN - EN	0.7	
	10.4	
Total Fte Proposed Allocation:		15.5

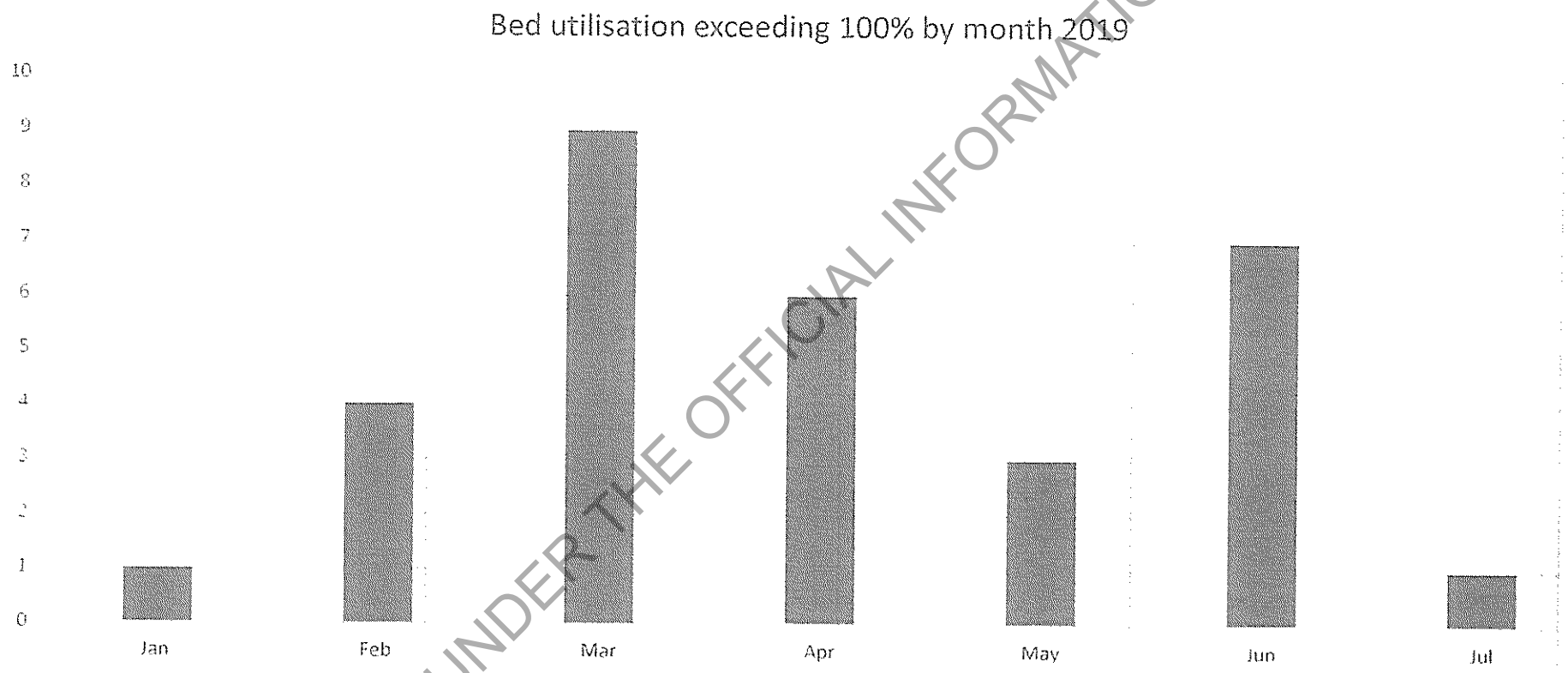
Patient Acuity Project

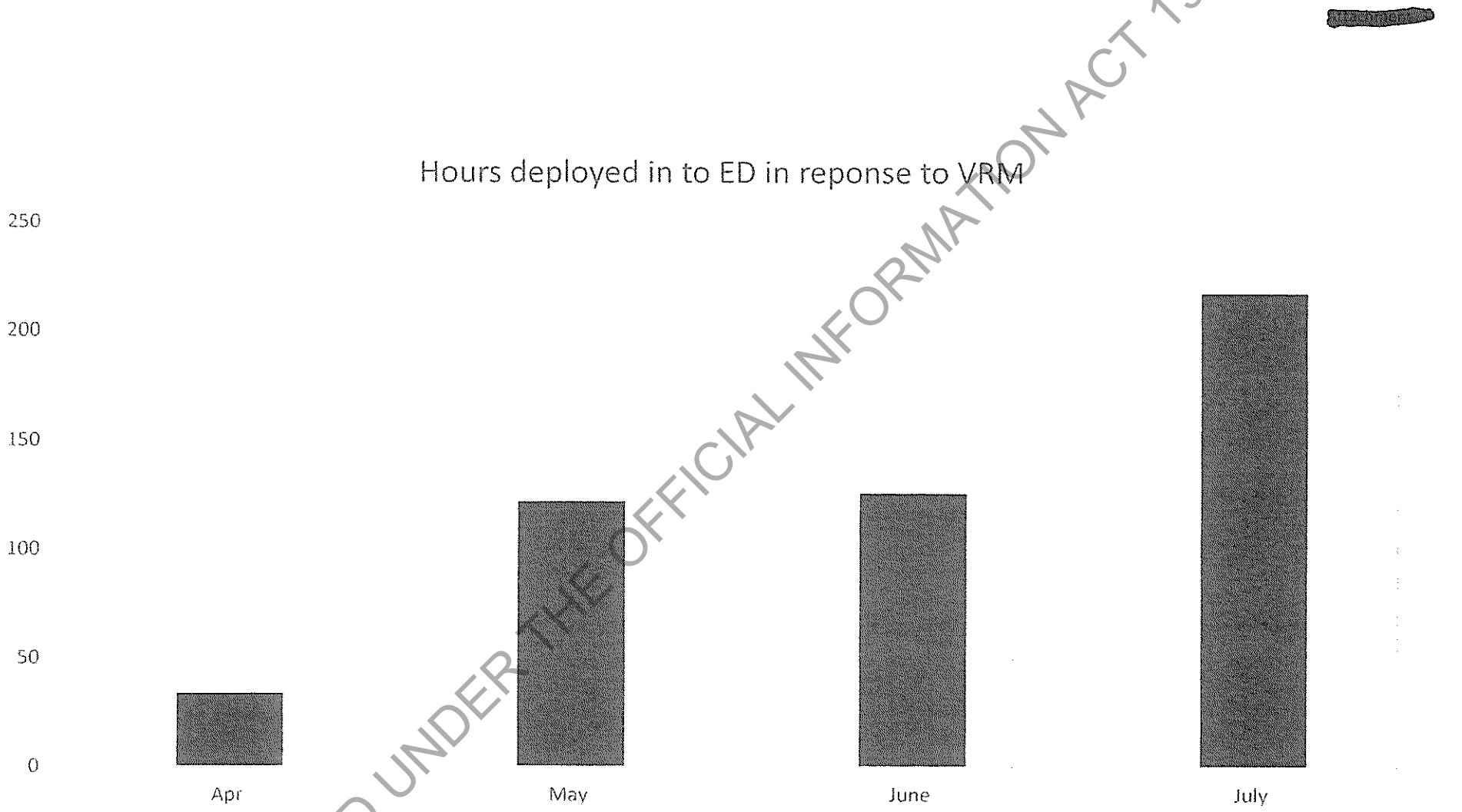
	Fte	FY19 Funding:	FY19 Actual Spend:
MOH - Notification	2.0	9(2)(b)(ii)	9(2)(b)(ii)
Balance Remaining:-			
Project Fte - FY20	2.0	*Senior Nurses*	

ED - Nn - 1118/1119								
Summary	*Year on Year Change*							
	13/14	14/15	15/16	16/17	17/18	18/19	FY20	
2205 - Senior Nurses	1.00	-	-	-	-	-	-	
2210 - Registered Nurs	21.64	24.65	25.86	26.40	26.30	26.35	26.35	
2235 - Health Service							1.40	
	22.64	24.65	25.86	26.40	26.30	26.35	27.75	9(2)(b)(ii)
Change per Year		2.01	1.21	0.54	(0.10)	0.05	1.40	
	Earthquake - Dollars							
	Earthquake - Fte			CNS	0.90			
				HCA	1.00			
	Earthquake - Dollars							
	Earthquake - Fte			CNS		0.80		
				HCA		0.97		
		CCDM	RN			0.93		
			HCA			1.40		
	Additional Fte				1.90	4.10		
	Also:							
	FY20	MAPU opened					11.00	



- Supernurse Hour Report
- Breaches Report >

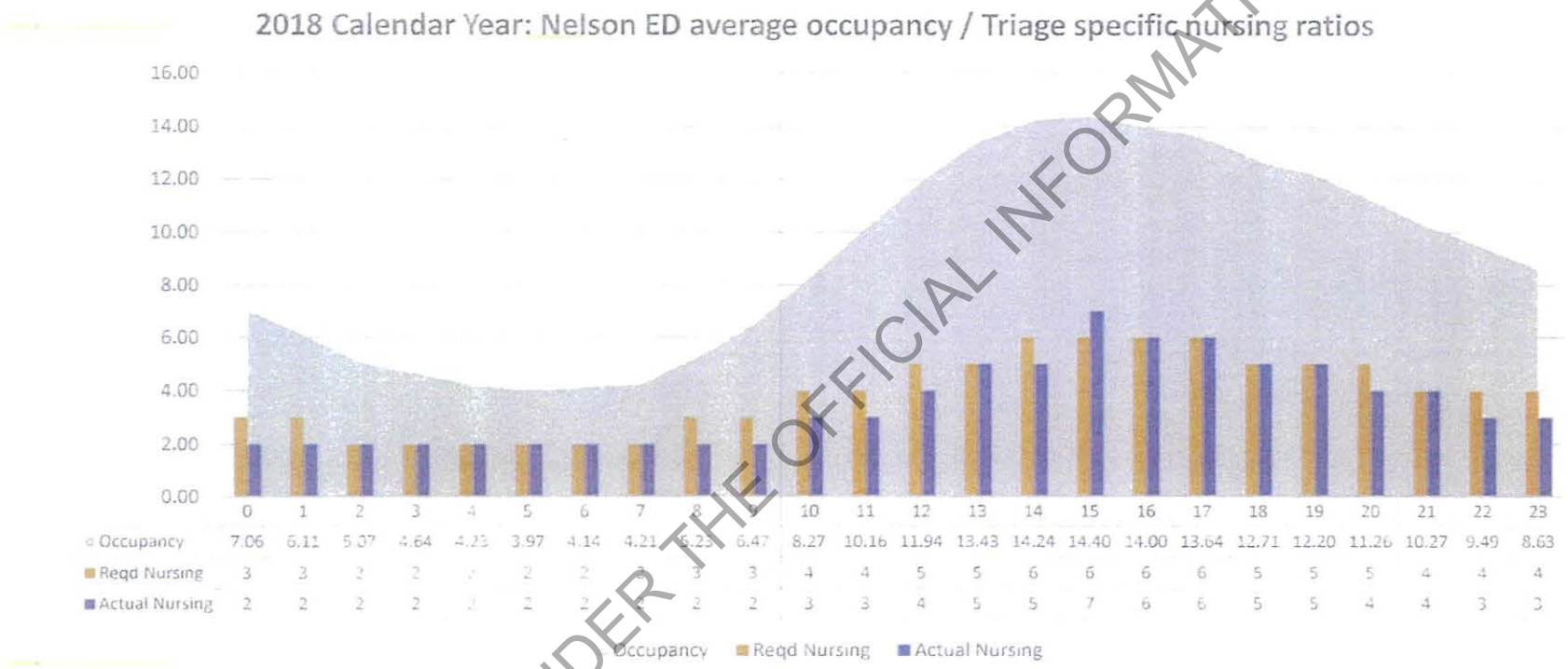




Includes S/L, Vaccancies, A/L

Nelson ED: Total Required and Actual Nursing

For 2018 Calendar Year



	0	1	2	3	4	5	6	7	8	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Occupancy	7.06	6.11	5.07	4.64	4.23	3.97	4.14	4.21	5.23	6.47	8.27	10.16	11.94	13.43	14.24	14.40	14.00	13.64	12.71	12.20	11.26	10.27	9.49	8.63
Reqd Nursing	3	3	2	2	2	2	2	2	3	3	4	4	5	5	6	6	6	6	5	5	5	4	4	4
Actual Nursing	2	2	2	2	2	2	2	2	2	2	3	3	4	5	5	7	6	6	5	5	4	4	3	3

On average through the 2018 calendar year nursing staff is below that estimated for the ratios required for triage-specific occupancies during two blocks: in the morning (8am to 3pm) and in the evening from 8pm through to 2am. As below, patterns are similar throughout the week, with some minor variations with the exception of Sunday which has a sustained higher occupancy through the morning.

NEW ZEALAND NURSES ORGANISATION

TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

26 July 2019

9(2)(a)

Associate Director of Nursing and Operations Manager
Nelson Hospital
By email: 9(2)(a)

Dear 9(2)(a)

In response to your letter to 9(2)(a) dated 24 July 2019.

Firstly, NZNO is disappointed to have received feedback from 9(2) on the way 9(2) was approached to meet with you, with urgency and at short notice, on Wednesday. This was a very distressing and upsetting situation for you to put 9(2) in.

NMDHB are aware NZNO have been working with 9(2) and had attended meetings with 9(2) in relation to this matter. Despite our close and ongoing professional relationship, no attempt was made to contact NZNO to attend this meeting. The letter requests 9(2) attend a meeting with you however, the letter was not presented to 9(2) until she arrived at the meeting.

It is completely inappropriate that NMDHB cancel meetings that have been scheduled in advance and your indication that you need to seek further advice before meeting (meeting scheduled 18 July 2019) and do not afford your staff and elected Health and Safety Representatives the same courtesy.

It is agreed consultation around an issue is a two way street and 9(2) and NZNO also remain committed to an ongoing dialogue. However, your response has highlighted NMDHB ongoing refusal to deal with the substantive issues that have been raised.

9(2) has agreed to amend the dates on the PIN that has been issued, as per Section 73 (b) of the Health and Safety at Work Act 2015. The revised date identified is now 31 July 2019.

To confirm, the PIN has not been cancelled. Both your request for the PIN to be cancelled and the situation described above contravene section 92 (1) of the Act.

9(2) has consulted with you before issuing the PIN, as per Section 69(3) of the Health and Safety at Work Act 2015. NMDHB have been given reasonable opportunity to address these concerns, including raising issues through Health and Safety Committee meetings, Health and Safety Management meetings, letters of recommendation and meeting with NMDHB to discuss the health and safety issues that have been raised and the accompanying recommendations. More recent events are detailed below and do not include reference to consultation through Health and Safety Committee meetings, Health and Safety Management Meetings or letters of recommendation sent in 2018.

Ground Floor
Momo Building
190 Bridge Street
Nelson 7010
PO Box 1795
Nelson 7040
T 0800 28 38 48
www.nzno.org.nz

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The letter of recommendation dated 11 May 2019 was not responded to within the reasonable timeframe of three weeks, stated by [redacted]. A meeting was requested by you for 6 June 2019 to which [redacted] attended. 10 minutes after the scheduled start time of the meeting, a third party advised the attendees that the DON, [redacted], was not onsite and they were unsure where you were, therefore the meeting was cancelled.

NZNO advised [redacted] had attended the meeting to engage with NMDHB and discuss the concerns raised, as well as the recommendations. As the required NMDHB staff had not attended the meeting they had scheduled, it was appropriate that the next step be for NMDHB to formally respond to the letter of recommendation, noting that the meeting was already scheduled beyond the reasonable timeframe specified in the letter of recommendation.

This did not occur and NMDHB rescheduled the meeting which went ahead on 16 June 2019. NMDHB formally responded to the letter of recommendation in a letter dated 26 June 2019 that was sent 28 June 2019, seven weeks after the letter of recommendation was sent.

[redacted] responded to this letter on 3 July 2019 and reiterated the earlier recommendations, highlighting that the immediate staffing concerns that had been raised were not addressed. A follow up meeting was requested by [redacted] and was scheduled for 18 July 2019. This meeting was cancelled the day before, where you indicated you had yet to discuss this letter with Manager of Occupational Health and Safety.

It is a concern that, despite NMDHB having received the letter two weeks prior, no internal communication with appropriate staff had occurred. It was requested by NZNO on [redacted] behalf, that the meeting be reinstated. This request was declined which lead to the PIN being issued via electronic communication. Following the meeting being cancelled and prior to the PIN being issued, [redacted] sought further advice from WorkSafe to ensure she was taking appropriate action in the circumstances. [redacted] intention and preference was to discuss the issuing of a PIN with you in person however, was not afforded the opportunity.

The Health and Safety Committee meetings, Health and Safety Management meetings and letters of recommendations clearly identify NMDHB contravention of the Act. This was also discussed in detail, including specific examples, at the meeting on 16 June 2019.

I refer to section 77 of the act, which supports the view that if the reference in the PIN to the letters of recommendation is a defect, this does not render the PIN invalid. The letters of recommendation is referenced in the PIN and NMDHB have sufficient information to understand the grounds for issuing this PIN. [redacted] would have been able to further discuss this with NMDHB on 18 July 2019 if the meeting had been reinstated as requested.

We remain committed to working together to resolve the concerns that have been raised and encourage NMDHB to take steps under section 79 of the Act, if that is required.

9(2)(a)

9(2)(ba)(ii)

8

9(2)(ba)(ii)

3: Issues/Alerts

- Need for funding for CNS positions after 27 January

9(2)(ba)(ii)

- Nursing resource inadequate for surges, little hospital capacity to respond to variance especially on weekends and nights.
- Need for extra ED RN 1800-0200
- NZNO involved in supporting ED RNs under unsustainable work pressure.
- Observations of suicidal patients; not meeting national standards
- Need for backfill for RN simulation training

9(2)(ba)(ii)

- Holding ICU patients for prolonged periods in ED

9(2)(ba)(ii)

Nelson Marlborough Health
TE WAIORA

Associate Director of Nursing/Operations Manager
DHB Office
Braemar Campus
Nelson Hospital

9(2)(a)

24 July 2019
9(2)(a)

Emergency Department
Nelson Hospital
By email 9(2)(a)

Dear 9(2)

We acknowledge receipt of your provisional improvement notice issued on 19 July 2019.

We were surprised to have received this notice and we have had to take advice about this. We understand that the consequences of not complying with your notice can be serious. While we acknowledge and understand the concerns you had raised, we were not aware of your proposal to issue this notice. We refer you to section 69(3) of the Health and Safety at Work Act. This requires you to consult with us about the proposed issue of the formal notice. Consultation on the issues you raise is a two-way street and we remain committed to doing that, and we ask that you remain committed to an ongoing dialogue to address the issues you raise.

We do acknowledge the issues you have raised previously, and you have our response to those to date. The issues you raise are complex. We are committed to safe staffing levels for nurses in ED, as well as across the DHB for all our staff.

Regrettably the solution may not be as simple as adopting your recommendations. We do welcome your input including making those recommendations and on other health and safety matters. We are working to respond to your letter of 3 July 2019, and will have that to you in due course, and will continue to consult with you about health and safety matters.

We also note that you are required to provide <u>at least</u> eight days after the notice is issued for us to comply and you have barely given us six days to respond. In addition the suggestion you make that we have contravened the Act is not set out in detail in the notice, and we would like to better understand your grounds for issuing this.

Despite the defects in the notice, we wish to meet with you to discuss the issues you have raised. As you have only given us until 26 July 2019 to comply, I need to meet with you at 4pm today in my office on level 4, together with 9(2)(a)

In the circumstances we ask that you cancel the notice.

However, if you are unwilling or unable to cancel the notice, our only option under the Act (section 79) is to apply for a review of the notice as the timeframes for doing so are strict.

Yours faithfully
9(2)(a)

Nelson Marlborough Health
TE WAIORA

AGENDA

NMH Worksafe Meeting

Monday 12 August 2019
0800-1030
DHB Office Meeting Room, Nelson

	Agenda Item	
1.	Welcome and Introduction	9(2)(a)
2.	DHB National & Local Environment • Team – funding and financial • Complexity and aging demographic • Changing Workforce • Changing care settings – MAPU/GP/MIC/Self	9(2)(a)
3.	CCDM national programme of work	9(2)(a)
4.	The ED story so far – including MAPU investment	9(2)(a)
5.		
6.		
7.		
8.		

TE WAIORA Nelson Marlborough Health

09 August 2019

Update on progress against work in progress identified in the letter to 9(2)(a) dated the 26 June 2019.

Paragraph One

Action:

Permanent pool staff are aligned to Duty Nurse Manager After Hours to enable immediate relief to staff to the Emergency Department and the wider hospital.

Paragraph Two

Actions:

1. In addition to the 1.7 FTE Health Care Assistant role and a Patient Support Person in Emergency Department, a group of Emergency Department nurses are meeting with the Emergency Department Nurse Educator to look at reviewing the proposed tasks which could be performed by Health Care Assistant's with the support of an education package and training to facilitate this. This will be in addition to the current tasks performed by Health Care Assistant's
2. A proposal for the extension of Mental Health Patient Support Person from original Thursday to Monday 2000hrs to 0400hrs out to cover Monday to Sunday is being costed up by Mental Health with a meeting to understand progress arranged with General Manager of Mental Health
3. Charge Nurse Manager is working with staff in the Emergency Department on the utilisation of this support as Mental Health has expressed concerns that they are being underutilised to date.

Paragraph Three

Action:

On 21 June 2019 an agreement was made to meet with staff after the first month of Medical Assessment Preadmission Unit opening to discuss impact on the Emergency Department. Meeting with staff was held 31 July. Issues that were identified as barriers to a better functioning of the Emergency Department post Medical Assessment Preadmission Unit opening included:

- Timely response by general medicine doctors to review medical patients in the Emergency Department leading to delays in patient flow of general medical patients
- Charge Nurse Manager Emergency Department/Associate Charge Nurse Manager Medical Assessment Preadmissions Unit/Associate Director Of Nursing Operations Manager to meet with Head of Department, 9(2)(a) on 12 August with focus of discussion being improving flow of medical patients

- Challenges with discharge data when transferring patients to Medical Assessment Preadmission Unit - currently being addressed
- Meeting with the Emergency Department staff to discuss data for first month post Medical Assessment Preadmission Unit opening will be arranged once data available.

Paragraph Four

Action:

Scheduled meeting with all Unions for the 15 August to look at data and have discussion around data and impact of additional Care Capacity and Demand Management staff in affected areas since January 2019.

Question to ask – is there any area that the data does not show a significant impact with the increased staffing levels, and if so is there a need to have a discussion on allocation/reallocation of the CCDM staff to areas of greater need which may lead to a change in focus.

Paragraph Five

Action:

Nurse Educator will be available for shifts to support staff and provide "at the bed education" for the team. This has been extended out to end of August.

Completed

Paragraph Six

Action:

Both Medical Assessment Preadmission Unit and Intensive Care Unit staff will now respond as able to Emergency Department Variance Response Management RED with particular focus on Medical Assessment Preadmission Unit staff as they are under the Charge Nurse Manager Emergency Department direction.

Completed

Paragraph Seven

Actions:

1. Meeting with Charge Nurse Manager to discuss reviewing Variance Response Management Standard Operating Procedures and escalation process in times of high complexity and occupancy in the Emergency Department – work in progress
2. The co-ordinator role in Medical Assessment Preadmission Unit will now work across both units, pulling patients into Medical Assessment Preadmission Unit and providing clinical support in Emergency Department when high complexity/acuity periods are occurring and Medical Assessment Preadmission Unit patient numbers allow
3. Meeting with Charge Nurse Manger Emergency Department to discuss Variance Response Management data coming out of the Emergency Department and request that the three supernumerary roles are added to the data as they are part of the Variance Response Management response when required. That is the Charge Nurse Manager, Co-ordinator and Nurse Educator roles.

Paragraph Eight

Action

Visit occurred on 24 July 2019 by 9(2)(a) , Ministry of Health, to come in an advisory support role to offer suggestions for acute services improvement and innovation.

9(2) met with the Charge Nurse Manager Emergency Department and Head of Department identifying possible barriers to better performance for consideration. 9(2) also followed the 'usual' journey for an acutely unwell patient through our admissions system.

Meetings also occurred with Gen Medicine team identifying possible barriers to better performance for consideration.

See attachment 1 for report.

Completed

In addition to the responses above, further work is occurring to provide more accurate validation of nursing workloads in the Emergency Department.

Issue:

National delays in Trendcare implementation in Emergency Departments
Currently there is no data capture of workload within the Emergency Department via trendcare which allows validation of workload and matching of workload with demand.

Actions:

1. Notification to the National Safe Staffing Healthy Workforce team that we wish to progress this work at Nelson Marlborough Health with some urgency. We requested that Nelson Marlborough Health are included in work being done at pilot site in Tauranga

   Completed

2. Charge Nurse Manager Emergency Department is attending a two day workshop in August which is hosted by Trendcare. The purpose of the workshop is to understand and explain the methodology of an Emergency Department trendcare programme and implementation

3. Following on from visit Nelson Marlborough Health will embark on implementing the Trendcare programme in the Emergency Department as a pilot with resource support from Safes Staffing Healthy Workforce

4. Nurse Practitioner Internship - currently reviewing funding process for Charge Nurse Specialist roles as part of the Nurse Practitioner Internship programme with Charge Nurse Manager Emergency Department and Associate Director of Nursing/Operations Manager, Nelson, Service Manager and Head of Department

5. Working with Emergency Department Head of Department and Registered Medical Officer office for joint funding venture for 2x Nurse Practitioner roles within the Emergency Department.

Actions still to be explored:

1. Increase in redirects to Medical Injuries Centre – meeting with General Manager Primary and Community to be arranged
2. Process of management of e-text to Emergency Department nursing staff after hours to relieve pressure of staff being constantly texted when off duty to be reviewed. Proposed recommendation is that e-texting of Emergency Department staff occurs from the Duty Nurse Manager after they have explored all avenues to support staff from hospital resource pool and Variance Response Management resource pool. Meeting with Charge Nurse Manager Emergency Department and Charge Nurse Manager Patient Flow.

Attachments Included:

1. Report: 9(2)(a)
2. Business Case: Transforming Care for the Acutely Unwell Patient....
3. Report: MAPU final pilot report – October 2018

Attachment 1

VISIT:	FEEDBACK ON THE VISIT TO NMDHB
PURPOSE:	To review acute flow
SPONSOR:	9(2)(a)
VISIT BY:	9(2)(a) r, Acute Services Improvement Advisor

9(2)(a) and team,

Thanks again for hosting me on the 24th July. Here are my observations / suggestions and recommendations:

General Medical Flow

1. Good attendance at the Board Round with MDT but missing social work / dietician and Drs. Particularly impressed with the level of pharmacy input into the wards and ED. Would help flow significantly if Drs could also attend the 08:30 meeting instead of 11.30. This may also help with the clash with the radiology meeting on Wednesdays. Is there an option to test this approach for a 2 week period? Suggest also reviewing the number of outliers as part of the test.
2. Only a few patients had EDDs on the Board. Suggested having the Board Round facing the Board and updating the board during the round. May be worth looking at the location of the board and looking into electronic boards at some point.
3. Discussed the need to have EDD times as well as dates to help focus discharge planning. Should aim for 90% of patients having EDDs within 24hrs. An option could be to look at the median LoS for the last 2 years and having a printed copy by the board for completion by the ward clerk on admission.
4. Suggest the Med Ward is also part of the Red to Green project. Discharges from the medical ward are pivotal to driving hospital flow and should be seen as a priority. Currently feels as though MAPU has drawn attention from the medical ward and is leading to protracted discharges later in the day. Afternoon discharges do seem to be delayed discharges from the morning due to late rounding and delays in documentation rather than early discharges for the following day.
5. Need to review the order in which Drs visit the wards and the order or rounding on the wards. Seeing the discharge patients first, followed by the sick and then the others would have a significant benefit for hospital flow. In addition, hospitals that run this system also tend to peel off a HO during the round to complete and finalise the discharge paperwork.
6. Some discussion at the SMO meeting around the need to have nurses present at the rounds. This could be supported if there is an agreement around timing and ordering of the rounds – CNMs are very keen to support and discuss this further.
7. Some discussion around the role and function of MAPU regarding admitting v assessment unit. Suggest close observation around the LoS to ensure the MAPU stay isn't adding to overall length of stay. Still some bedding in to do around the role and function of this unit and to ensure that the Med Ward does not become the poor relation.
8. Would be worth looking at clinical criteria for discharge particularly for patients who have weekend EDDs. Could you aim for starting Monday morning with 2 free medical beds to ensure early flow and prevent a queue building at the start of the week?
9. Could a nurse from the community help with early supported discharge? CDHB have nurse from the community as part of the POAC team who go to ED / MAPU and wards and 'pull'

patients back to their GP teams. This is particularly helpful for LTCs such as COPD / heart failure where there is high risk of readmission and little value add from the medical stay.

10. Discussed frailty. Very little taking place around frailty generally. Worth looking at the BoP PARIS model and discussing with other areas such as Cap Coast, Lakes and CDHB – all of whom have frailty programmes in place. Is there an opportunity for more geriatrician team support to 'pull' from the wards / ED?

ED

1. General feeling that patients are being held too long in ED once a decision has been made. This may be due to unavailability of beds and desire to 'package' and clerk everyone before they leave. Surgery, ortho, paeds flow ok – issues are with gen med. This would reflect the observations on the ward where discharge planning could be slicker (as discussed above)
2. Suggested using HCAs more in ED. Suggest levels of competency: Level 1: stocking/ tidying, Level 2: Obs, Level 3: venepuncture / cannulation / ECG etc. This will allow qualified staff to work at top of scope and allows for better use of resources.
3. Discussed the need for Hospital HealthPathways – this is being fed back to Streamliners and MoH
4. Discussed secondments across flow areas, i.e. ED / MAPU / Med Wards. This will build relationships and an ability to 'walk in others shoes'.
5. Very little happening around frailty. Suggest visiting Bay of Plenty to see this in action.
6. Not currently working a 'front of house' model. This is run by NPs in BoP and is very successful. Suggest looking at this model of care.
7. Some EDs use their Acute Demand / POAC nurses from community in ED / MAPU and wards. These nurse 'pull' patients back to the community and transfer the care back to the GPT. EDs see these as hugely helpful as they act as navigators, particularly when there are elderly patients with social issues and clinical issues that can be managed by general practice. Another option is to have a GP working within ED / MAPU as a Clinical Lead / GP Liaison to both manage this and observe for opportunities (could 9(2)(a) support this?).
8. Discussed some opportunities to unpick the data by shift leader and see if there is any correlation between who is in charge that day and poor flow. Some places are exploring this and are finding that there could be more of a correlation between the shift leader than how busy the dept or hospital is. The same applies to use of Radiology e.g. MRI / CT / USS – are there variances in ordering depending on who is in charge?
9. Briefly discussed ARC attendances and the need for proactive management and support of ARC but didn't explore further. Again – BoP have done some good work around this.

Ops Centre

1. Good conversation at the SMO lunchtime meeting with 9(2)(a) following her sabbatical. Good examples of ops centres in the UK with senior doctor input that would be worth trying in NMDHB.
2. Shared with the ops centre an example of an IT solution to support bed management which included: counting down to day of discharge/ EDDs / clinical criteria for discharge. May be worth some discussion and investment in IT to support the role and function of the Ops Centre.

Ambulatory Care

1. Could be opportunities to move more of the current day case activity into the Community. CDHB are doing work in this space and welcome to visit. Currently moved blood tx, infliximab, intragam P and working on others (will send appropriate docs separately). Also discussed with 9(2)(a) and will send info.
2. Same question applies to renal dialysis in ICU? Could this be managed in the community environment in a dedicated ambulatory facility?
3. Could you work with an existing GP practice as a jointly funded venture to support this and grow the community skills? This could then be used as a 'skills incubator' for other community clinicians to rotate through? Access for patients is far better and it would release capacity in the acute setting.

Other

1. Ward 10 doing good work on discharge planning with their board and clinical criteria for discharge. We discussed stretching them further by updating the board immediately at the time of rounding and starting to use EDD times as well as dates. This will enable them to challenge what will happen between now and the patient due discharge time.
2. Could also try the 4Qs on the ward to see if there is an improvement of the % of patients who know when they are going home and what needs to happen to get them home?
3. General discussions about the need to develop a culture and change process. I am happy to send over / support some work around facilitation skills and leading HealthPathways type workshops.
4. Discussed the options for developing shadowing opportunities for SMOs / clinicians keen to develop leadership skills. Can be done in non-clinical time and would support leadership development.
5. Briefly discussed acute flow at the SMO meeting – there is a keenness to look at a dedicated acute list and pre-optimisation of acute patients to prevent post-op complications and delayed recovery. Some good examples of this available in the UK.
6. Is there an opportunity to look at elective smoothing to support more surgical activity in summer when medical acute bed pressure is less?
7. Acute clinics? Are there opportunities for acute clinics in gen med / cardiology that would prevent admission from ED? Examples would include patients with exacerbation of their heart failure.
8. ICU flow. Suggested at the SMO and ED meeting that there might be opportunities to improve flow from ICU. Patients may be delayed due to labelling and requirements for isolation room and watch required. Also briefly discussed the renal dialysis in ICU and whether this could be considered under the discussions around an ambulatory care centre which could include dialysis / infusions etc.?

Current situation ED

- Increased demand/workload
- Decreased nursing levels (disestablished Clinical Nursing Specialists (CNS) positions January 19 (originally funding for Drs in ED post Kaikoura earthquake – unable to fill so CNS positions instead; funded ended); RN 1.7 FTE position devolved 30/6/19 - these were additional ED nurse 8 hr/7 days positions to cover busy 'L Shift' created post nursing strike; plus loss of 1 mental health nurse position (not situated in ED but lots of support) previously available M-F)
- No validated Trendcare module for EDs in New Zealand; Care Capacity Demand Management (CCDM) – model to match nurses to workload/patients; part of this is Variance Response Management (VRM) system shows frequent Critical Care/Significant Care capacity deficit (often occurring outside business hours when there is limited capacity from other wards)
- Pool of casual nurses already scheduled to work/working at capacity
- Escalation pathway ineffective for hospital (Phone duty nurse, sometimes results in nurses from other wards – though often no one available; perception 'sort it, don't call again')
- Text system – requests sent to permanent staff not already working (to come in early or on days off)
- Redirection of suitable patients to Medical & Injury Centre - not an option/closed between 2130 & 0800)
- Planned reviews of Trendcare & CCDM in some wards but no indication of anticipated review/analysis of FTE in ED (first tranche – between now and 2021). Note – Nelson didn't have analysis part of variance management – required to report progress to MoH
- Lack of required number of nurses in ED at times for tasks e.g. resuscitation, observation of suicidal patient (not meeting national standards); insufficient nurses in ED to be able to release ED nurse to escort patient out of ED
- Some security presence (orderlies who have been trained in de-escalation techniques) – often not sufficient (aggressive/threatening patients); lack of support for orderlies (threatened)
- Medical Admissions Planning Unit (MAPU) – new unit opened 1 July 19. Purpose to ease pressure on ED by improving flow of patients; extra 10 hospital beds; pilot (Aug-Oct 18) showed reduced waiting time and overall stay in ED; First 4 weeks - Monday – Friday only. 24/7 from 29/7/19.
- Nurses consistently working without breaks (particularly on night shift)
- Nurses required to work long hours/overtime (particularly on night shift) – Nurses have an ethical obligation/duty of care to patients where they feel they can't leave on time if there is no one to hand their patient onto.

Impacts – Psychosocial Harm

- Short notice requests for change of shift impact on work-life balance/downtime and ability for nurses to bounce back from often stressful work situations
- Feeling obligated to work overtime and concern about resulting effects on other commitments outside of work
- Feeling unsupported e.g. inability to take break (due to lack of relief available) after death of patient
- Distress/stress re inability to provide adequate level of care to patients (due to staffing levels) and nurses fearful of loss of registration (and being subject of investigation of complaints re mistakes/level of care)
- Fear/stress re security issues/lack of adequate fosecurity to help deal with aggressive patients
- Fatigue from long hours/lack of breaks/interruptions to down time when not at work – can also lead to increased mistakes being made
- Poor morale – nurses frequently in tears, expressing feelings that they "can't do this anymore"
- High accumulation of leave/inability to take leave when wanted (due to minimum staffing level requirements); being forced to take leave and resulting impact/shortages in ED

Existing WEPR processes

- Elected HSR (for workgroups)
- HSC's (HSR grouped together to form HSC – 2 in Nelson Hospital, HS&W advisor, administrator to take minutes) – meet 2 monthly – good commitment from HSR - high absenteeism from management, very slow resolution of issues raised, poor feedback on what is being done as a result of Safety First reports
- 9(2)(a)
- HS Management Committee – (senior management with decision making ability, chairpersons of HSCs) meets 2 monthly (off months of HSC) – lack of accountability/ownership; lack of understanding of issues; lack of understanding of responsibilities (perception is that this is very hierarchical & issues raised criticised) 9(2 9(2)(a)
- Nurses monthly meeting – nurses can add to agenda and raise issues/concerns which is can be feed into HSC meeting

Reporting

Safety First – electronic reporting system for recording health & safety incidents/near misses – workers encourage to report but report; receive acknowledgement but poor feed-back about any outcome

ED Manager monthly report to GM Clinical Services – *Outcome/response to issues raised speck to* 9(2)
Bi monthly Senior ED meeting (Senior doctors, nurses etc)
Minutes from HSC & HS Management Committee meeting

Consultation timeline

Issues relating to ED nursing levels raised through HSC meetings, HS Management meetings and letters of recommendation (4 letters of recommendation sent since August 2018)

11 May 2019 – letter of recommendation and raising concerns dated 11/5/19 sent by 9(2)(a) to – requesting response from NMDHB in 3 weeks – not received until 7 weeks later

6 June 2019 – meeting requested for this date by . Purpose of meeting to discuss concerns raised in letter of recommendation. Meeting attended by 9(2)(a)

6 June 2019 - meeting cancelled 10 minutes after start time as 9(2)(a) was not onsite and location of 9(2) not known.

16 June 2019 – rescheduled meeting held

28 June 2019 – NMDHB formally responded in writing to 9(2)(a) letter of recommendation dated 11 May 2019.

3 July 2019 – letter sent by 9(2)(a) in response and stating concerns raised re ED nurse staffing not addressed. Follow up meeting requested by 9(2) and scheduled for 18/7/19

17 July 2019 – meeting scheduled for 18th July cancelled by 9(2) stating she had yet to discuss letter with 9(2)(a) Requests by NZNO Organiser for meeting to be reinstated declined.

18/7/2019 (approximately 2330hrs) - PIN issued by 9(2)(a) (HSR ED Nurses) sent by email to 9(2)(a) 9(2)), PIN dated 19/7/19, date to remedy 25/7/19.

24/7/2019 – 9(2)(a) attending assessed training. Approached by 9(2)(a) 9(2)(a) 9(2)(a) at 1520 hrs and asked to attend meeting with 9(2) at 1600hrs (note – training not scheduled to finish until 1630 hrs).

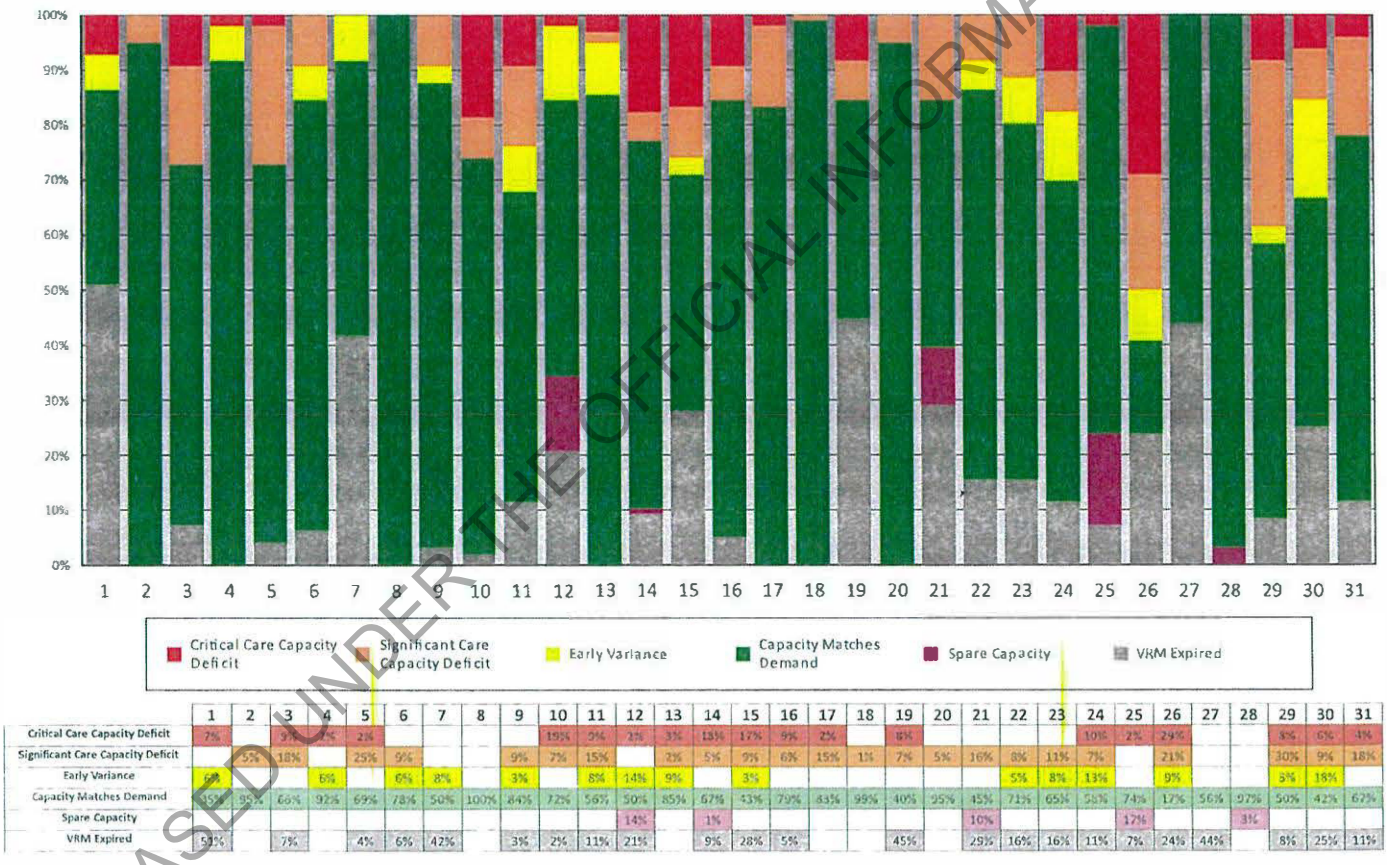
9(2) attended meeting – 9(2)(a) also present. 9(2) given letter requesting she cancel PIN and stating that PIN contravened. 9(2) said she was not prepared to cancel PIN, but extended due date for remedial action until 31/7/19 on request from 9(2)(a) .

26/7/2019 – Letter sent to 9(2)(a) from 9(2)(a) – upholding PIN and expressing concerns re tactics/response from NMDHB.

Last Months Daily 15 Min VRM Status - % of Total

May 19

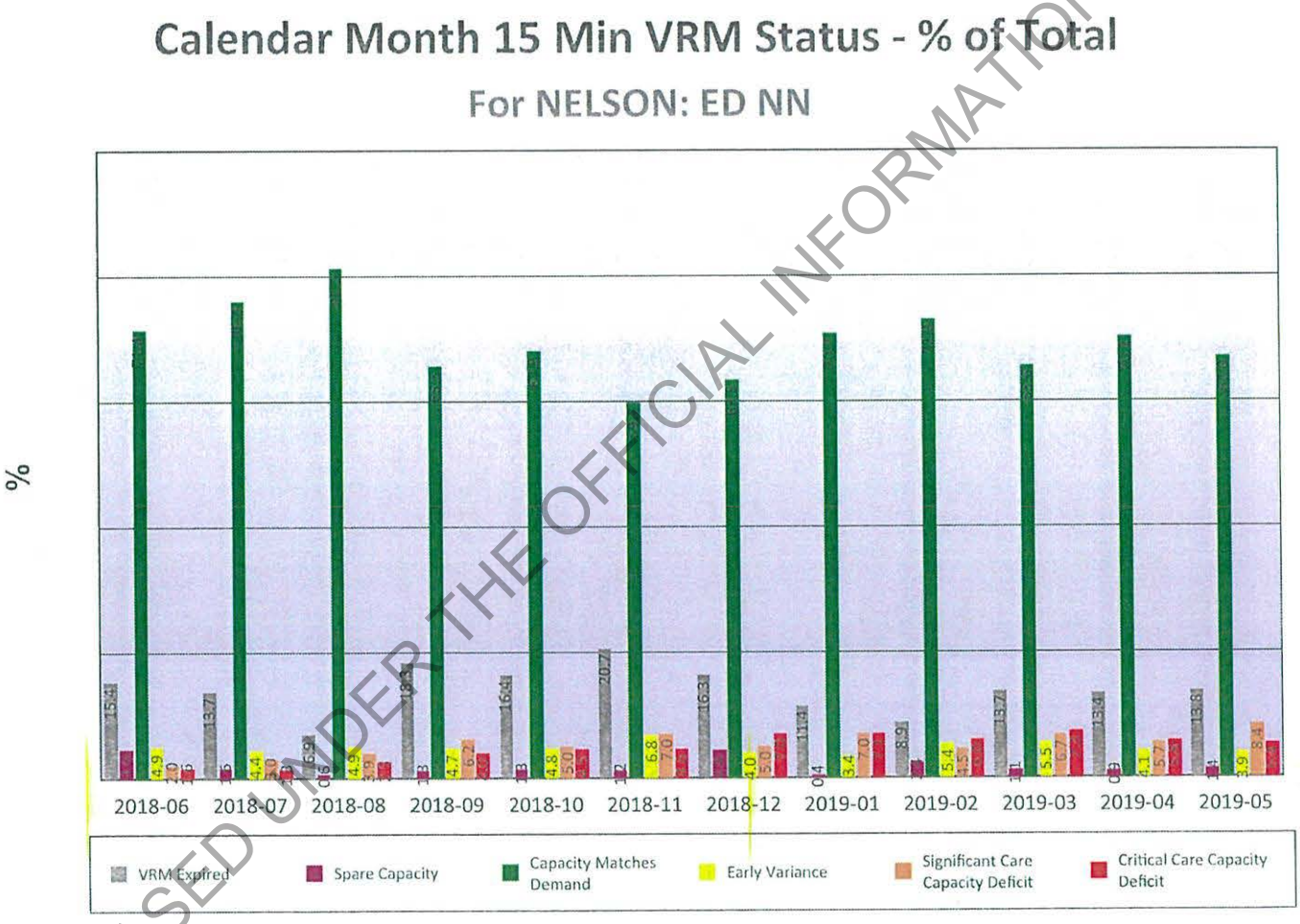
For NELSON: ED NN



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Critical Care Capacity Deficit	7%		9%	2%	21%					19%	5%	2%	3%	13%	17%	9%	2%		8%					10%	2%	29%			3%	6%	4%
Significant Care Capacity Deficit		5%	18%		25%	9%			9%	7%	15%		3%	5%	9%	6%	15%	1%	7%	5%	16%	8%	11%	7%		21%			30%	9%	18%
Early Variance	6%			6%		6%	8%		3%		8%	14%	9%		3%							5%	8%	13%		9%			5%	18%	
Capacity Matches Demand	15%	95%	66%	92%	69%	78%	50%	100%	84%	72%	56%	50%	85%	67%	43%	79%	83%	99%	40%	95%	45%	71%	65%	58%	74%	17%	56%	97%	50%	42%	67%
Spare Capacity												14%		1%							10%				17%			3%			
VRM Expired	51%		7%		4%	6%	42%		3%	2%	11%	21%		9%	28%	5%			45%		29%	16%	16%	11%	7%	24%	44%		8%	25%	11%

NMDHB Data Quality Caveat:

Caution is advised in the interpretation of the data in this graph. Although the information is relevant to the DHB's ongoing work related to the PIN, inaccuracies in the data have been identified due to issues with the reporting model. To the uninitiated the information could incorrectly appear as accurate whereas, and with benefit of hindsight, what it signifies is need for improved data capture methodology.



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Demand by triage specific nursing ratios Nelson ED: data methodology

The basis of these calculations is

1. EDaaG. An accurate to-the-minute data collection tool.
2. The protocol timing looks forward. Eg 0800 = 0800 – 0859
3. College of Emergency Nursing New Zealand (CENNZ) acuity categories and base staffing ratios.

Acuity category	Nurse: patient ratio
Triage 1: critical	3:1
Triage 2: high risk/time critical needs	1:2
Triage 3: Stable	1:3
Triage 4 and 5: Minor	1:4

4. There is no validated Trendcare module for EDs in New Zealand. While triage code is not necessarily a predictor of ongoing acuity, it is the best proxy that is currently available.
5. The demand data provided (orange columns) is averaged over the specified time period, so while it demonstrates base staffing requirements it does not reflect the need to be able to flex up over base staffing levels at short notice (there will be some shifts with higher demand than shown on the graph, requiring Variance Response Management), nor the ability to assist other areas in times of lower demand.
6. Nursing numbers (blue columns) are for RNs providing actual nursing care. It does not include coordinators or triage nurses. Ministry of Health Level 4 ED service specifications (2013) require a dedicated triage nurse 24/7 and a dedicated coordinator 24/7. In Nelson at present on night shift the triage and coordination role are combined, removing one RN for these two additional roles. The morning and afternoon coordinators also do ambulance triage.
7. The nursing numbers shown are current Nelson ED RN mandatory staffing. They do not reflect VRM responses that have occurred over the time period, or temporary staffing such as the 1800-0200 shift that was in place for 7 months but now withdrawn.
8. There is a healthcare assistant from 1300-2130, that is not included in the graph. This role might be considered 1/3 of a RN.
9. Increase in demand is reflected in 2018/19 FY data as compared to 2017/18 FY.

30.7.19

(2)

11 May 2019

9(2)(a)
Associate Director of Nursing

Dear 9(2)(a)

Re: Emergency dept. Nelson. Nursing
"Recommendation under Schedule 2, clause 1 (f)". Health and Safety at Work Act

Details
Unsafe workloads in Nelson ED have increasingly been reported to senior nursing management through a variety of avenues (including: safety 1st, departmental meetings, NZNO, and health and safety meetings,). Despite the MECA 2018, nurses are repeatedly being required to endure very heavy and stressful workloads.

In the 7 months since 1 Sept 2018 until 16 April 2019, 239 shifts have been reported as VRM red and/or orange, with very limited or no resources available to assist under the VRM (variance response management) system. (See attachments).

The majority of these instances (VRM red/orange) occur outside business hours, and even with support from the CNM M-F 0700-1530, 83 day shifts needed extra staff. The least resourced shift is Saturday night. Afternoon shifts are consistently under resourced.

This data ***includes*** the shifts that were formerly reinforced by having a CNS, particularly weekend afternoons. The CNS positions were disestablished January 2019 and staffing is worse.

In addition, information in charts (attached) already submitted to you by 9(2) 9(2) demonstrate that we need 2 nurses more per 24 hr period.

CCMD scrutiny has commenced in Nelson, with some wards/depts. scheduled for FTE analysis. We have not been informed of an anticipated date for analysis of FTE in ED, but it is not in the first tranche.

In September 2018 in reply to my previous recommendation under schedule 2 you emailed that nurses should be "assured that nursing executive is strongly committed to addressing safe staffing" for the "identified areas under pressure and issues related to high workload demands on nursing".

Recommendation
CNS positions to be re-established as they were until January 2019.

In addition to this, a minimum 2 additional RN's are required 7 days per week. One RN should be rostered PM shift each day. One RN should be rostered N shift each day.

In addition to this, an additional RN is required on Saturday night shift (or 1745-0215 shift).

Within 3 weeks, please provide a plan of progress to increase base FTE as per this recommendation. **(Recommendation)**

Under Schedule 2, clause 10 (2), the PCBU, Person conducting a business or undertaking (hospital) must, within a reasonable time, respond to my request.

Can you please respond in writing within 3 weeks to advise us that you intend to provide the information, or if not please provide a written statement setting out the reasons for not providing the information.

Yours sincerely

9(2)(a)

H&S rep ED

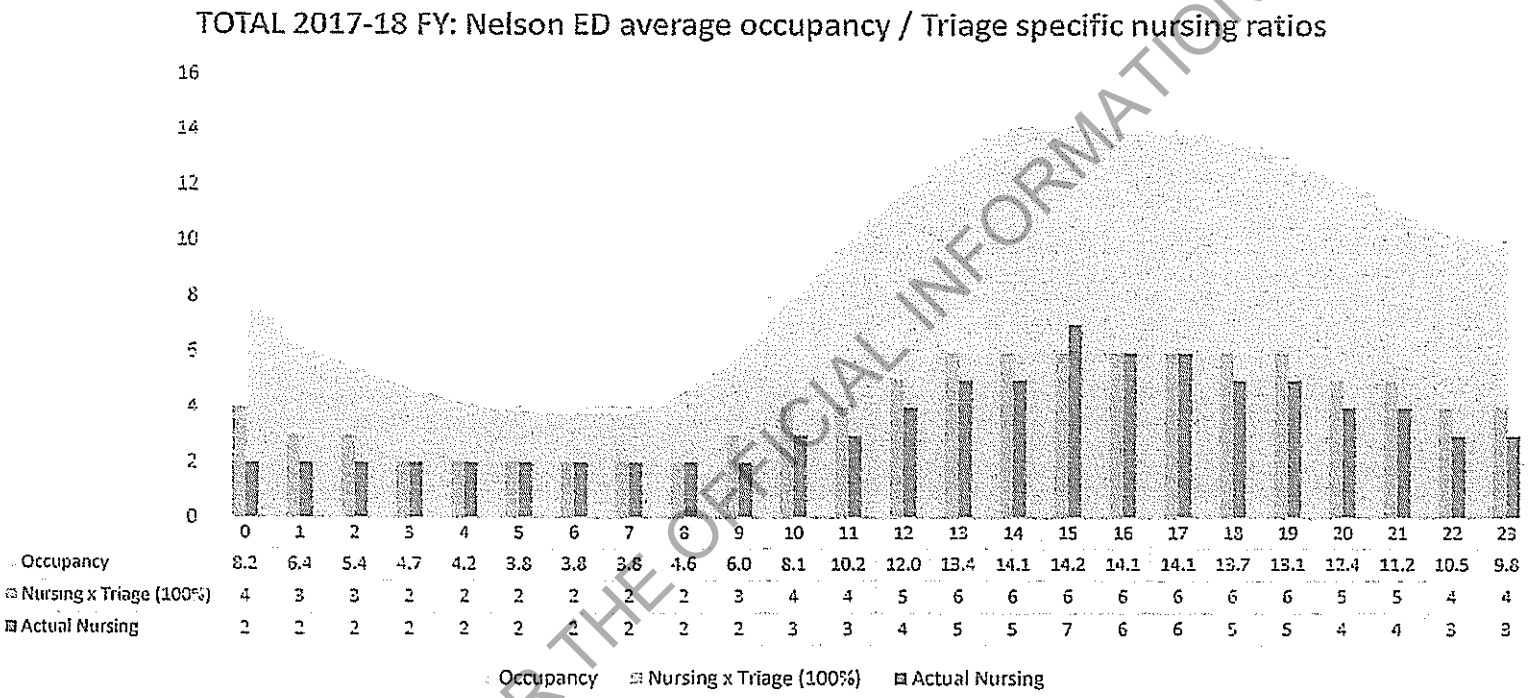
Cc 9(2)(a)

Attachments –

1. Total required and actual nursing for 2017-18 FY and MAPU period
   ED average occupancy vs nursing ratios. 2 charts.

2. VRM red/orange by shift. This is taken from the daily shift reports completed by nurse coordinator in ED, please note that the night shift data corresponds to the day of the week when the majority of hours are worked. I.e. Sunday night on the chart is an actual Saturday night 2245hr start).

TOTAL REQUIRED AND ACTUAL NURSING FOR 2017-18 FY



Across the 2017-18 FY, staffing is short according to nursing ratios required for triage-specific occupancies during Morning (9am to 3pm) and in the evening from 6pm through to 2am.

NMDHB Data Quality Caveat:

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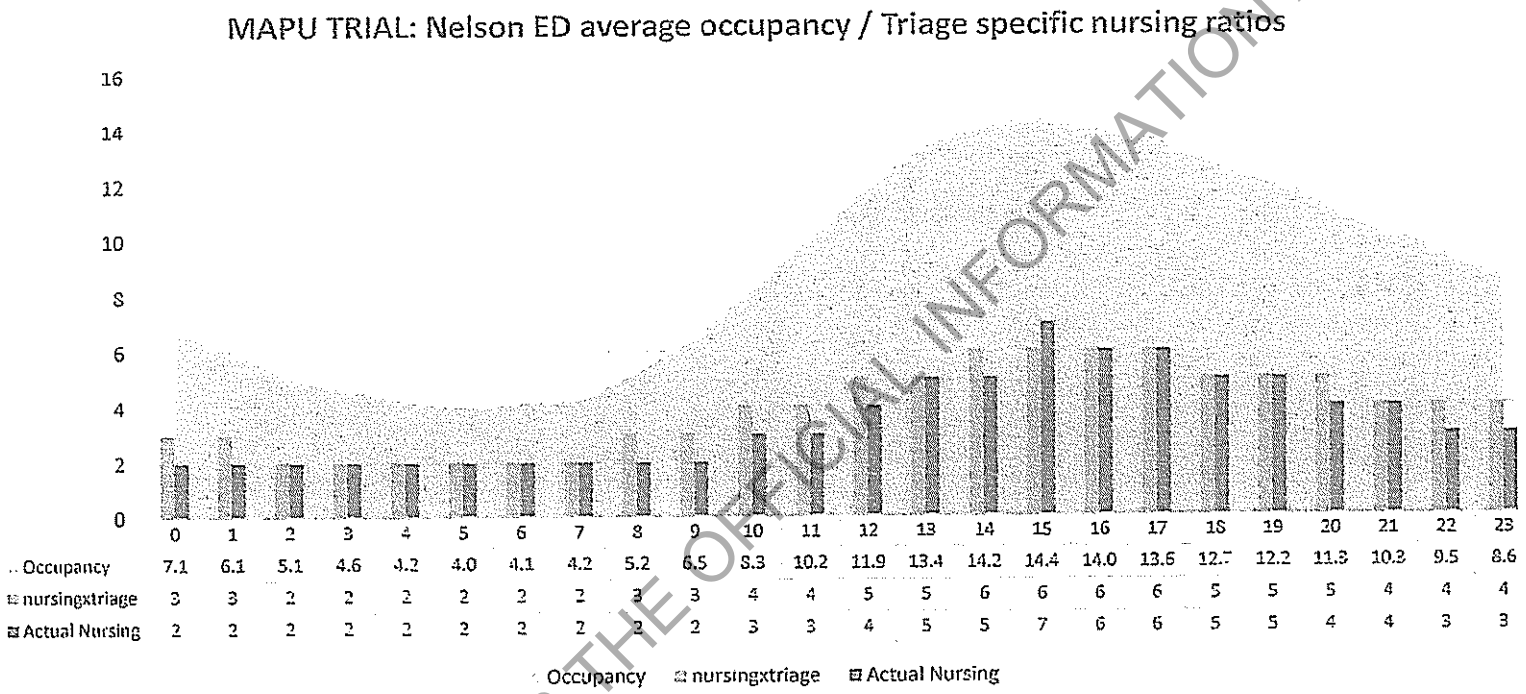
MAPU PERIOD, 30 July to 7 October 2018



During the MAPU trial period, understaffing follows hour-of-day patterns to other times of the year, however 11 hours of the day were understaffed during the MAPU period versus 15 hours of the day during the total financial year, indicated some relief to the ED may have been offered by MAPU.

NMDHB Data Quality Caveat:

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VRM red/orange by shift (from shift reports) 1 sept 2018

	night	am	pm
mon	5	13	15
tues	7	8	14
wed	9	14	11
thur	8	15	16
fri	9	11	16
sat	5	7	13
sun	15	15	13

NMDHB Data Quality Caveat:

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-16 april 2019

9(2)(a)

Date:
Attendees:
Minute Taker: Manager mental health & addict
Place

	Action Required
Health and Safety Concerns for staff in ED ***Meeting open 11.04*** 9(2) ***- Issues raised without resolution*** 9(2) *talked to the H&S issues raised by staff and the effects it was having on staff in ED (refer to recommendation to NMH under the HS&E Act requiring a response to recommendations).* 9(2) noted it was the 4th letter of recommendation, since it was raised August 2018.. The formal letter to NMH under the HS&E Act (the Act s. 2 (1) (f)) asked for a response in writing to recommendations to fix the problem within 3 weeks. 9(2) consulted with HSW Manager prior to issuing the first recommendation. Previous recommendations have included hospital wide issues, this letter addresses concerns raise in ED Nelson specifically. 9(2) –Requested that 9(explained the HS&E Act 9(2) Explained that the intention is that 9 will receive a response from the DHB. 9(2) indicated she represented 9(2) as 9(2) was not present. It was suggested NMH review the act to become familiar with HSR responsibilities. 9(2) – spoke of ED Nelson staff Health and Safety concerns raised in the letter including stress, staffing levels, moral distress and lack of protected off duty time with repeated request by text and phone to start early or pick up additional shifts. Clarified Recommendations from 2018 were on behalf of all hospital nurses and they had been raised in the ward, at HSR meetings and HSR Management meetings **Clinical Nurse Specialist Disestablishment** 9(2) indicated staffing is not safe in the hosiltal. HSR rep meeting 2 months ago ED Nurses Recommendation letter was discussed. Clarified this is a formal process withing HSAW Act and a written response was requested withing 3 weeks. This has not been received. The meetings that have been scheduled have both been outside of this timeframe. 9(2) clarified HSR recommendation letter and 'reasonable timeframe' is mentioned in the act and HSR is to determine what a reasonable timeframe is. 9(2)(a) joined at 11.13am. Recap earlier discussion. 9(2) again clarified the purpose of this letter of Recommendation and the purpose of the meeting was for 9(2) to provide any additional information or respond to DHB questions. If further clarification is required on NMH responsibilities within the act, they should seek further advice outside this forum. Continue discussion on CNS roles disestablished in January 2019. 9(2) noted that CNS roles are coming in more and more into NMH and outlined the plan around the CNS function and Nurse practitioner and discussions being held with 9(2)(a)	9(2) – a written response within one week. If addition one week required this will be communicated with 9(2) .

9(2)(a) and the medical team and potential funding constraints for the CNS role but that some funding for nursing FTE is in the nursing budget.

9(2) spoke of professional obligations to Nursing Council to report unsafe situations, including unsafe workload. This includes escalating to DNM, VRM that is inadequate and does not provide support or response and MECA escalation pathway.
Futher conversation of off duty time not protected. An example of multiple text being sent within 24 hours to cover the same shift.

MECA agreement – decline workload and/or patients when full. It was noted ED is unable to do that. ED are required to keep patients when wards are full. The DHB do not have additional nurses available to provide care to these patients.
Discussed Safety First incident reporting and shift notes regularly completed by ED nurses. Also discussed letters from senior doctors raising concern at workload and ED overcrowding.

Data to capture issues and assess need vs availability – general discussion

Monthly reports, variance response and safety first data, bell graphs, no trend-care, patient minutes in department continues to increase.

9(2)(a) - showed graphs with VRM status - significant time in red, orange and yellow (up to 28%) and 6% of the month in critical understaffing. Noted that the impact of the temporary L shift (timed to finish 30 June), and the new MAPU slightly improve the situation but don't solve it (MAPU only deals with medical patients at certain times). Staff do see MAPU as positive. Noted high over-utilisation of beds at times, high acuity patients with 4 to 6% redirects. ED is resourced for 17 beds, often use coridors, resus and an interview room for patients, up to 25 spaces. This is 32% above resourced, inc orthopaedic beds.

It was noted safety first relating to staffing events reduced while L shift in place and MAPU will not solve patient flow issues.

During MAPU pilot, ED situation improved but the ED remained under significant pressure.

Pressure on nurses affects critical incidents. Lack of time and being stretched and unable to be relieved after critically unwell patients for any debrief or respite in most situations. . Keeping patients in high-vis areas is inefficient because of the need to move from available bed to another bed.

9(2) - noted that we are looking at options and escalation processes but need good data on all this. Measuring flow and acuity provides a good marker. Will need to look at all solutions as FTE is the not the only solution need to look at impact of MAPU, responsiveness of surgical teams, patient flow with Quality – Clinical Governance support team involved. For security and support care we are also doing an audit of the last 20 patients to deliver what we need - HCA, security?

Discussed short term plan, as this is a critical situation. CNS model change and removal of L shift are having immediate impact on ability to be safe at work and safely provide care. Confirmed RN roles were backfilled while CNS roles in place. Discussed NP intern role very different to CNS and NP does not support nursing need as CNS did.
Discussed NZNO and NMH meeting this afternoon. NMH have no plan for additional resources for ED.
Discussed no ED acuity tool and unable to complete CCDM FTE calculation. Consider being reviewed using other tools.

DHB agreed to continue to monitor and improve VRM. ED have been noting if requests for additional support have been made and if this need is being met. This will continue. These requests are being made more than once a day as there are regularly not enough resources to provide care. Discussed information gaps in DNM shift reports and if they were able to provide response when resource required.

9(2)(a) asked about whether debriefing processes are good and staff support processes. Discussed that debrief process can come across as blame focussed. Discussed the moral distress and fatigue nurses continue to experience with limited stategy to alleviate this. There is an open door to 9(2)(a) and medical staff and the social worker which is good. At critical times, there is not time to debrief. Sometimes 'hot debriefs' if these are able to be facilitated. The accumulative effect, including health and safety concerns, of often being unable to debrief was also discussed Over 500 shifts with variance, 32 texts within the last month in the group text number plus individual phone calls to off duty staff requesting to come in and start early. Processes we have are inadequate and thinks improving escalation processes wouldn't fix the problem and suggested that shift reports give accurate data. Time-lag of CCDM review in ED. 9(2) talked to the effect on staff and said it is now getting critical with nurses.. Time spent escorting patients is high. Inadequate security and inadequate response to Mental Health patients who are being put in high visibility areas and not provided 1 to 1 care which is the care they require. . Request a review a month after MAPU comes in. This has resulted in flow challenges which impact on normal function of ED. Major issues are after hours. Concerns about staffing attrition due to current workload Discussed the unsafe situations nurses are in almost daily, with nurses often crying because of the unsupported and unsafe situations they find themselves in. Clarified they are not upset for the patients, but because they are unable to provide the care that patients require when they present to ED. 9(2) - noted that the NMH nursing FTE calculation will involve ED. Unable to provide timeframe. 9(2) - noted that the HS&E Act requirement is separate from the MECA funding and emphasised the requirements under the Act. 9(2) - noted that staff safety unit doesn't have the software under the CCDM process but it can use other measures. If loaded onto Trend-care this would help. 9(2) – This is an urgent project we need to get up and running and turn our minds to. 9(2) – We would like a written response in writing per the Act. 9(2)(a) – Agreed that this would be sent within one week from the meeting. If unable to send within one week of the meeting, this would be communicated to 9(2) and the response may be provided within two weeks if this extra time was needed.	

TE WAIORA Nelson Marlborough Health
We value: Respect - Integrity - Teamwork - Innovation

HUMAN RESOURCES

Braemar Site
Private Bag 18
Nelson 7042, New Zealand

26 June 2019

9(2)(a)
ED Health and Safety Representative

Dear 9(2)

Formal response to recommendation under the Health and Safety at Work Act 2015 Part 3 – 69 (1)

Following our meeting of 13 June 2019, NMH wishes to respond to your letter and recommendations.

First, we thank you for conveying the issues that staff and ED need to deal with and the impact this has on staff. Across our system there has been and continues to be work on initiatives to help manage the increase in acuity/demand in ED.

As you will be aware the challenges currently being experienced within ED are multi-factorial and whole of system related and because of this the future focus to resolve these challenges will also be multi-factorial requiring a whole of the hospital response to support ED going forward.

We have given careful consideration to the types of situations conveyed and the concerns from ED staff and wish to respond to this to outline our plan to address the situation. A significant part of that plan is to focus on the barriers to patient flow both into and out of ED and the need to change the way we work together as a system going forward.

The plan involves a number of key initiatives and response measures:

The MAPU business case was focussed on promoting patient flow, reducing demand on the ED by ensuring patients have more timely access to medical assessment and decision making, reduction in non-compliance against 6 hour target, reducing bottle necks within ED and reducing medical outliers to mention a few. The impact of the MAPU 10 week trial showed a positive impact on the hospital flow and in particular ED and given the benefits identified through the post implementation review this business case has now been approved by ELT and the Board to go "live" on 1st July. The implementation of MAPU was based significantly on the impact this area would have in ED by decanting the stable medical acute admissions thereby freeing up more time to focus on the acutely unstable unwell. This will have a demonstrable impact on the activity within ED and will go a long way to support the challenges currently being experienced however, we also acknowledge the fact that this is not the panacea to all challenges.

The decision to have the ED CNM oversee the MAPU was to provide connectivity and oversight between the two areas and ensure that the seamless flow does occur to an area that is staffed and ready to accept. The "pulling" of patients into this area will be a crucial part of that process which the CNM and MAPU team will work closely to achieve

4

A review of the MAPU performance and impact will occur monthly post implementation to ensure we are meeting the KPI's identified and to iron out any issues that will undoubtedly be uncovered during the initial bedding in phase

Added to the funding of MAPU the following is also work in progress as a result of the communications had to date:

1. Analysis work done based on VRM has led to us putting in place a CCDM bureau of dedicated FTE to provide support at short notice into areas of high demand in the hospital with a particular focus after hours. Thursday through to Monday. Currently the rosters for both the CCDM pool and permanent pool staff are being reviewed to ensure the staff availability matches the time of need for the service to ensure greater ability to respond to VRM as it occurs. This response will be reviewed monthly as to impact within the ED. The casual pool staff will work to support the permanent staff in that after hour period.

2. Permanent HCA roles have been secured at 1.7 FTE for ED. To add value, these roles are also being reviewed with the potential for extension of scope, e.g., taking blood pressures, temperatures etc. Whilst it is appreciated these roles do not provide direct patient care they are able to be tasked to free up time for RNs to focus on the acutely unwell presenting at ED.

3. The introduction of MAPU will provide 10 additional medical beds into the hospital which will create greater flow from the front door. Measuring the appropriate use of MAPU a crucial component of the post implementation phase and will be part of the monthly review process. Whilst there is a "bedding in" process I would expect it to be fully functional and showing benefits to the ED team early within the first month.

4. Currently the CCDM allocation of staff is being reviewed as per plan to ensure the resources are in the right place. The data analysis will give good understanding as to the impact of that allocation. Following analysis discussion will be had with our NZNO partners as to future focus of the FTE.

5. To ensure greater availability of staff across the hospital the Nurse Educators will be assigned on the floor for their full shifts until the end of July and which time we will review the staffing levels, sickness and capacity issues currently being experienced. The will include Nurse Educators in ED and MAPU. By having all educators, across the district supporting the nursing workload on the floor during the day shift it is expected to see a reduction in demand and use of the pool staff to ensure they are available for critical areas of need given they will be assisting in filling roster gaps in their own areas.

6. Work has commenced with CNM ED/MAPU, and ICCU to look at a response from ICCU to assist ED staff in ED when appropriate during increased demand periods.

7. Significant project work is underway on VRM involving the CNM ED / MAPU focussing on appropriate nursing resource and our response to acute pressure and understaffing. This work is underway with the 9(2)(a) and once completed will be fed back to the staff.

8. We also have the opportunity to have the national lead for acute service improvement, 9(2)(a) , visit during July. Both your CNM and HoD are working on a programme for her visit and she will be in the department for at least 2 hours.

9. Recently the MoH Deputy Director General for Systems and Monitoring walked through our Nelson facility including ED to understand some of our facility issues first hand. This ensures awareness of our issues as we seek to pursue an interim rebuild.

We acknowledge the recommendations from your report in relation to staffing. At this point our focus is on identifying the barriers and finding further solutions before looking at the formal FTE for the area. That will be completed as part of the CCDM process. It should be noted that this work will become a focus of discussion with NZNO as work together to support the department.

9(2)(a) has a meeting planned with the ED nursing team on Friday 2 August to review the impact of MAPU on ED.

Yours sincerely

9(2)(a)

9(2)(a)

3 July2019

9(2)(a)

Dear 9(2)(a)

Re: Emergency dept. Nelson. Nursing

"Recommendation under Schedule 2, clause 1 (f)". Health and Safety at Work Act

Thank you for your letter received 28 June in response to my recommendation sent to you 12 May regards unsafe staffing (nursing) in Nelson emergency department.

I note the letter is dated 26 June yet was sent to me after a previous letter from Ms Kiesanowski dated 27 June (which was later rescinded by you).

I also note your letter is titled H+S Act part 3-69 (1). This part of the Act relates to a provisional improvement notice, my recommendation is under schedule 2 and is not a provisional improvement notice and a PIN was not issued.

I am responding to the points documented in your letter.

1. VRM is already in place and has been for many years. The response is invariably inadequate to support ED nursing staffing.

   The only refinement in recent years is to include redirection of suitable patients to MIC (medical and injury centre) an option which cannot be utilised from 2130 approx. until 0800 as the service is closed. The redirection guideline requires secondary survey/observations/EWS, which cannot be done in a timely manner if the triage nurse is busy with patients presenting, therefore patients are not redirected.

   Your description on how it will work in future, is an explanation of what is expected now and is currently ineffective. Since the figures presented to you in the recommendation, for the month of May 2019 there were 24 days when VRM resources and ED workload were mismatched. I.e. shift reports identified unsafe or risky care and unsafe staffing. Could you please identify how I as ED Health and Safety representative and the ED nursing team can have confidence that the revamped VRM will operate differently? Please can you identify how the ED team/NZNO delegate and ED team will be involved in monthly reviews of VRM success?

2. The HCA role is not a new addition to the ED nursing team and has been in place since April 2017 (1.0 FTE) and since October 2018 has been made permanent and 1.7 FTE. However, this does not address the immediate need for an increase in nursing staffing addressed in my letter of recommendation. There is also the RN supervision/delegation aspect of HCA care, which is impaired when nurses are required to take unreasonable workloads. I.e. may not be able to adequately supervise HCA actions.

3. MAPU opening 1 July with restricted hours and closed during the weekends (ED busiest time) for the 1st month. This is not likely to improve nurse workload in ED and does not address the immediate ED staffing need as it will take time to be open 7 days a week.

   Even during the MAPU trial last year, (when CNS positions covered some of the busier weekend shifts) ED required 11 hrs day extra nursing FTE (attachments already provided on the 11 May recommendation). Your expected improvement "within the first month" is not immediate or guaranteed. What are MAPU KPI's that will be reviewed monthly? What is 'appropriate use of MAPU' and how will this be measured? Can you identify how I as ED Health and Safety representative and the ED nursing team can have confidence that MAPU will address the immediate need for an increase in ED nursing staff raised in my letter of recommendation?

4. CCDM allocation. What is the difference to this and Point 1 – VRM? Data presented by 9(2)(a) "Nelson ED: total required and actual nursing 2018 calendar year" attached (the time period of which included CNS positions which have since been devolved) indicate 13 hrs day ED is understaffed by (at least) 1 nurse. L shift is disestablished 30 June 2019 with no plans to extend or review FTE. Can you identify the difference in this point and Point 1 – VRM, as well as how I as ED Health and Safety representative and the ED nursing team can have confidence that MAPU will address the immediate need for an increase in ED nursing staff raised in my letter of recommendation?

5. Nurse educator deployed to work clinical shifts in ED. The educator is away on leave 2/52 of the 1 month that you intend her to work in ED. Please can you state if other educator(s) will be deployed to ED, and which shifts/FTE? AM shifts only (educator "usual shifts") does not address the immediate staffing shortfall on the afterhours shifts identified in my letter of recommendation.

6. ICCU response
    a. This is a project and does not provide immediate relief
    b. How often are ICU in VRM purple over last 3 or 6 months? I.e. available to assist other areas?
    c. How often are ICU in VRM purple and able to assist when ED in Yellow/orange/red and require assistance?
    d. How is this different to point 1 VRM? VRM systems are already hospital wide.

7. VRM response. Significant data has been collected and distributed for years, including the CNM ED monthly report which has repeatedly documented critical risks, minutes in dept., use of casuals and sick leave, overtime, safety first numbers and in recent months there has also been collation of minutes in ED for ICCU patients waiting bed(s) in ICCU. Can you identify the difference in this point and Point 1 – VRM, as well as how I as ED Health and Safety representative and the ED nursing team can have confidence that MAPU will address the immediate need for an increase in ED nursing staff raised in my letter of recommendation?

8. 9(2)(a) . This is a project and does not provide immediate relief to staffing needs in ED. Please could you identify who is the project sponsor and how will NMH ensure all recommendations are implemented immediately?

9. MoH Deputy Director General of Systems and Monitoring. This does not appear to be a project and in this context does not seem to address immediate concerns raised in my recommendation.

Your letter has not addressed the recommendations I made in the May 11 letter and I reiterate my recommendation under the H+S Act that CNS positions be reinstated and an increase in FTE as per the recommendation of 11 May.

Your letter provides no plan to increase base FTE, nor is FTE in ED scheduled to be calculated via CCDM process. The last of the scheduled CCDM FTE calculations for NMH is Jan 2020, and ED falls beyond that scheduling. Your letter also coincides with the removal of 1.4 FTE (L shift ceased 30 June).

Recommendation

CNS positions to be re-established as they were until January 2019.

In addition to this, a minimum 2 additional RN's are required 7 days per week. One RN should be rostered PM shift each day. One RN should be rostered N shift each day.

In addition to this, an additional RN is required on Saturday night shift (or 1745-0215 shift).

Within 2 weeks, please provide a plan of progress to increase base FTE as per this recommendation. **(Recommendation)**

Under Schedule 2, clause 10 (2), the PCBU, Person conducting a business or undertaking (hospital) must, within a reasonable time, respond to my request.